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SACRAMENTO, CALIFORNIA; TUESDAY, SEPTEMBER 23, 1997

10:00 A.M.

MS. FINBERG: I'm Jeanne Finberg from Consumer's Union, and I wanted to take a look at this brief outline that details some of the problems, principals, and options in the consumer information area. And I apologize in advance for the roughness of this document. I know our time is very valuable. And I wasn't able to spend the time that I would have liked to on it because I got distracted by other important things. But I'm hoping that it lays out most of the important issues. It will give us a chance to talk a bit about what we want to recommend in the consumer information area.

First, I listed the problems, and -- oh, the other thing I wanted to say is my bias in terms of the consumer perspective is pretty obvious, and so I've tried to include options and other perspectives. I'm sure I have not been completely successful in that regard, and I'm sure you'll let me know issues that have been left out or language that should be revised.

In terms of problems, the first broadest statement is how consumers receive their health care, which has changed dramatically with the shift from fee for service to managed care. Most consumers either do not understand the changes or have not been able to adapt positively to the changes. I need to add more specifically, consumers do not always understand the relationships and the responsibilities of plans of health

groups and of providers.

Consumers have scanty information available to help them in choosing a health plan medical group or primary care physician. Scanty information is available to consumers about the quality of care being provided in the system at various levels. Information that is available is often incomplete, biased, unintelligible, or not helpful. Consumers are not confident that they are getting the information that they need to inform them about important decisions. Consumers are confused about how to get help when they have problems in managed care.

So maybe I should stop for a moment and see if people have any comments or responses to the statement of problems. Yes.

MR. ALPERT: I'm struck, Jeanne, and the consistent theme in this says to me the big problem is that consumers are not the epicenter of either the delivery system itself in its efforts nor are they the epicenter of the regulatory oversight of that system. And the combination of those two is a fatal flaw, if you will, at the moment. That's why we exist.

I think if you -- each sentence says essentially that. We don't have information. They're afraid they can't get care. They're afraid they don't know how the system works, et cetera, et cetera.

MR. WILLIAMS: One question I'm curious about is how you differentiate the problems as they relate to managed care as opposed to how they relate to

non-managed care forms of health care.

MS. FINBERG: Yeah. I actually did not attempt to do that. I assumed that our mission was to focus on managed care and how it -- if it needs to be improved and the ways in which it needs to be improved. So I just mentioned fee-for-service as a very preliminary this is where we are. But I've really tried to just look at the managed care system and plans, assuming that's our jurisdiction here. And I don't find it that helpful to compare. I know there's problems in fee-for-service, but it isn't really what we're here for.

MR. WILLIAMS: My question was really to what extent are these problems created by managed care? Are they historic structural problems? Are they health care delivery system, and therefore represents perhaps bigger problems, more important challenges for the commission to think about and ways that this problem can be resolved?

MS. FINBERG: Right. That may be very true.

MR. ZATKIN: Do you think there are consumers that have better information than others according to the systems that they are involved with? For example, PBGH or CalPERS? And how would you rate those for providing information?

MS. FINBERG: Certainly, some consumers have better information than others, and I think Pacific Business Group does serve its members probably the best, you know, that we have here. I don't think that that

meets all of our goals, but it's better than what a lot of consumers have. And I don't think I would attempt to rate them.

MS. SEVERONI: I would just make one point about Pacific Business Group on Health because they've been mentioned. On our recent visit there, I was asked if I would consider serving on a committee that would help with new materials going out to consumers, and I suggested that instead of having someone like me or another person sit on a committee like that, would they consider a member advisory committee where actual users from each of the plans might be able to participate and help them review and update materials. And the response back to me was simply much too task oriented here to institute anything like that because what we might hear is that the materials don't work.

And so I think just, you know, whether you're a purchasing group or a health plan, there aren't any mechanisms right now that test to see what you're asking us, because there really aren't loops back to the consumers regarding whether or not the information is helpful.

MR. GALLEGOS: Jeanne, I just want to comment on a couple of levels. First as a health care provider who is still in private practice, one of the few still remaining under the current system and having practiced before and seen the transition, I can tell you that these points that you've brought up are points that

I've certainly heard over the years from my own patients who have transitioned from fee-for-service into some form of managed care.

And I might say that from a legislative perspective over the years that I've been in the legislature, these are repetitive themes that I've heard from constituents as well, and not just myself, but other colleague in the legislature. And that's why you saw a number of bills this year introduced that helped to provide more information to the consumer, because that was a theme that many of us in the legislature had been hearing from our constituents in our communities that that was something that they felt was very difficult about accessing and understanding this new system.

MS. FINBERG: Thank you. Maybe I should move on to the principals. The consumers' ability to understand how to choose and use their health plans has been critically important. Consumers should have unbiased standardized information about health plans, medical groups, and physicians. I probably should add in there facilities such as hospitals as well. Consumer information should be useful and targeted toward assisting consumers in making choices about health care and health care coverage. Consumers should be informed or be able to inform themselves about the managed care system and the ways in which their health care may be affected by plan or group policies or practices and how to most effectively navigate their way through their health plan.

I'm the typist here. Apologies for mistakes. And a couple people have pointed out to me I need to include principals about special information or additional information needed for a special population or people with chronic conditions or special medical needs.

Full and accurate disclosure of appropriate information can serve to foster competition and best practices. And consumers should be well-informed of both internal grievance processes, external resources, and relevant regulatory agencies that are or may be available to them when they have a problem.

Any comments on the principals? Ones I left out?

CHAIRMAN ENTHOVEN: One of the things that strikes me as I looked at this was full and accurate disclosure. It's kind of like there's so much of it and it's so complex that there's also a challenge to find the right balance. I've been studying on my own EOC to see if something I want is covered in that. And it's so long and complicated, I can't even find it. And so it was a real challenge.

MS. FINBERG: And it is a challenge. But I thought that it was important for us to agree that that was an appropriate goal. And then we could look at what steps we can take to move closer to that goal, because I think that even you would be better served if you had better information to use to navigate that EOC. And just think about what the average consumer faces.

MR. WILLIAMS: Yeah. I think these look like some very good suggestions. Other things that you might think about considering is that consumers tend to absorb information in different ways. Some people read. Some people prefer seeing it visually. And we might think about different forms of presentation of the information as well as availability in different languages and support for different populations and different native languages. So I think all of this is very constructive.

MS. FINBERG: Good. I'm glad you mentioned that. Different forms and different languages should be available to serve all consumers.

MR. KARPF: Jeanne, a word that you used several times that's important to me is standardized, the ability to make appropriate kind of comparisons. And also I put on my provider hat when I have a set of standardized information items I must provide to multiple different people. It's a lot clearer, a lot more efficient than providing different data to different entities. That becomes very costly and hard to interpret. So I'll continue to emphasize that.

MR. GILBERT: The only comment I'd like to make, Dr. Karpf, because I think your point is very well-taken, in terms of making sure the information is comparable, one of the difficulties is when you actually proscribe the specific language which occurs with both the DOC and the DHS is, no. 1, you often use words at a literacy level that really aren't -- really aren't

applicable to some of the populations in terms of their ability to understand it.

Two, you lose some flexibility being able to describe things in a way that is the most useful for your members. And yet the flip side of that is your point, which is if you don't make it in some -- if there isn't some box, then you can't even compare across one plan or another. I don't know if you thought about that, that balance between --

MR. KARPF: I don't think the language has to be standardized. I think the principals have to be standardized and the data elements that one is going to try to collect, if possible, have to be -- there has to be a consensus about it so we don't have multiple different organizations asking us about data, and they don't match.

MS. FINBERG: Maybe I should move on to the options then, because that's the hardest part and probably the least complete part of this document.

Let me mention the ones that I thought of or that other people had suggested to me. Develop consumer friendly information on managed care, how to use a plan and group, how to get help when things go wrong, and how to pursue a grievance, develop incentives for plans to provide more comprehensive information on quality of care rules and restrictions and options to consumers in a standardized format, mandate reporting of standardized information to an independent party.

And then it seemed like we would want to

discuss here who the information goes to, if it should be government, if it should be private, if it should be a regulating agency or an independent body.

Other options would be to require plans and groups to disclose information on treatment guidelines and criteria used for treatment and referrals, require plans and groups to disclose information on financial incentives, develope incentives or mandates to improve quality measures, particularly outcome measures, require governmental agencies to work cooperatively in producing consumer information and responding to consumer complaints or requests for information.

And probably a similar option here would be a requirement the same that would apply to plans and groups and providers to work cooperatively to produce information and to respond to complaints within their system. And then finally to create an independent agency or entity that would produce uniform consumer information.

CHAIRMAN ENTHOVEN: Comments on those options?

MR. RODGERS: Was your intent in creating a new agency general consumer information about health care health plans similar to what we've seen in terms of report cards, or do you have a different thinking or thought on that?

MS. FINBERG: Well, in terms of what this option meant, I was trying to look at ways that we could solve these problems using these principals. And one way

is to have something completely independent that isn't a regulatory agent that doesn't have a stake in the system at any level but is solely responsible for collecting and reporting information.

MR. RODGERS: Do you have a model in mind?

MS. FINBERG: I don't have something in mind.

MR. ZAREMBERG: I think I talked to a couple of task force members about this already. Part of the problems are like all the problems in insurance coverage. I don't think people read their policy until they need it.

MS. FINBERG: Right.

MR. ZAREMBERG: And so I look at some of this information, and I think Anthony asked the big question there. Do we have any models in any other areas, whether it be homeowners' insurance, whether it be traditional indemnity insurance or fee-for-service? How many people read their coverage before they ever needed it? And so are we saying there's an overall problem there, and we need to address that problem that covers all insurance issues? Or is this unique just to health insurance or unique only to managed care? Is that what we're addressing?

And I look at, you know -- and I preface that because I think we need to go through some of these things and prioritize and maybe -- and I don't know whether Ellen's pole will help identify some of those things, or whether you did this poling. And let me

further amplify on that.

I think it's important to do that because -- to prioritize because I think if we use other insurance polices as examples, people don't necessarily read it until they need it. And the question is, do we want to put out information in advance now that people can use to help make their choice of plans, and what is the information, and can it be concise and address the things that are most helpful to them?

For example, you have in here require plans and groups to disclose information on financial incentives. Now, I appreciate that. Is that a significant aspect of how people make decisions? Is that important? Is that something we consider important? Is that what people make use of as a decision-making process? And I just use that as an example, because I don't know, and I'd like to make sure that if we're going to make more information readily available at the front end as opposed to when they need coverage, that they have information that they want.

Is Helen's pole going to look at some of those things? Is this anecdotal or do people prioritize on how they want to make their decisions in purchasing health care?

MS. FINBERG: I haven't done any poling. And I think that you raise the correct questions and make a good statement about what priority do we give this information. Is it information that consumers should have

and should use? I can answer those questions from my point of view.

It is important information. It is information that I think is highly relevant and that I would use in making a decision. It probably would be helpful to pole our members to get our priorities and our thoughts about these options.

I don't think that would tell us what consumers want or what consumers use. I think that is harder to find out even if we had the resources to do that poling. It's very tricky when that information isn't available now, and so people might not really understand how it could be used or what it means.

MR. ZAREMBERG: Can I make one follow-up point? You mentioned in here about -- and I don't know if it's a proposal, but setting up an independent agency, government agency. And before I would recommend or support setting up an independent government agency, I would want to make sure that it's something that the public is going to utilize, not just to have an agency, but something that they can digest and utilize at the right time and serves them a purpose. And I'm not sure I have that information.

CHAIRMAN ENTHOVEN: I think even more than that, one of the problems with a government agency is what we've seen, say, with the experience of OSHPD is then people who don't want to disclose the information use their political power to, you know, to prevent it. And

the entities that are supposed to be reporting have fifth amendment rights and can exercise their rights and raise issues of fairness and so forth.

The big advantage of the buyer/seller relationship is with CalPERS and Pacific Business Group on Health. Say they want information. The health plans or the hospitals can't just appeal to their fifth amendment rights and say, you know, "You can't make us provide it" because the purchaser can say, "We're not talking about whether you have a right to provide the information or not. We're just not going to do business with you if you won't inform us" --

MR. ZAREMBERG: Can I ask a question? In your work on this background, you mentioned that CalPERS and PBGH has some of the best information. Do you know if they poled their information to see what information they thought was relevant to see what was relevant? I know they had the books and the plans. Is that what we should use as a model? Or do you feel that that's an adequate -- have they done some, you know, scientific marketing research to see if that's how people are best satisfied? Once I digest the information, is that what leads to more satisfaction? And have they found that -- do we have anything to go by?

MS. FINBERG: I'm not the best person to speak about Pacific Business Group on Health, but as I understand it, they have done a survey, and they do have some information about that. I think they're relatively

new to the consumer information part. Maybe you want to speak on that.

MR. SPURLOCK: I can actually talk a little to that. I sit on the CCHRI executive committee. You have the 1995 report that was just published. And we actually struggled mightily with how to make this document exist because there is information on quality of health plans and health plan comparison. That's statistically valid so the methodology is valid, tools were valid.

The problem is how do you display the information. And this is actually the third report. And we did focused testing as our primary source of information. Even then we were confused and we came down with the way the report actually played out, trade-off between competing interest and best gestalt about what works best with consumers. That was the first problem, displaying information.

The second problem is how useful is this in the decision-making process. And that's the part we don't know. And I think that's the part that's right from research. I brought that issue forward to CCHRI that we should use this as an opportunity to see how much consumers actually take this kind of information. Are PBGH and CalPERS, whoever is using this kind of report, the web, is that acceptable, useful if it's giving out employee benefit packages during enrollment? Do they look at this?

What I suspect sometimes, are they

influenced more by commercials? Some of the things in the newspaper? What is the information used that consumers want? Maybe a lot of them have different types of needs, and we need to do a lot of different formats. But I think those are areas that are really open subjects that have not been answered, and we're just at infancy.

CHAIRMAN ENTHOVEN: Peter.

MR. LEE: You really did what our board group didn't do, provide a range of options least intrusive. I want to note the earlier options that are unintrusive, couple observations.

One, I think we should be focusing as much or more information on how to use systems as information about choice. And I think Jeanne does that in principals. And we need to look at that in terms of description as well. Whatever we recommend, the choice will be limited. And even when people make a choice, we don't know what goes in it, what they're going to use as they go into them. And that's one observation.

I think in terms of recommendations, the ones that will probably have consensus is on the very unintrusive ones on the top of Jeanne's list in terms of developing consumer information. I think that's sort of an encouraging market to do that, accreditation agencies to look at how information is provided to plans. The place where we need to focus our discussion is around plan dates. And the block of discussion, what is required of plans and, you know, Ellen, you jumped to the top end,

further end of developing another agency; that there would be a lot of discussion about that.

The block I'm really most interested in is the more middle block of what is required disclosure and what do we mean by required disclosure.

And rather than sort of say what I think should be required and what shouldn't be in which ways, I think maybe for our next discussion for the present task force -- what is needed here is breaking out different sorts of information that must be required or is available upon request, and those are some of the issues that I think are really rubber meets the road on information disclosure.

Is it something that always should be provided the moment someone enrolls, provided when a certain incident happens? A denial, and then a new set of information? Or is it available when someone says, "I want to know this." If someone wants to know what formula my plan has, do you attach that in the evidence of coverage? I don't think it's in the evidence of coverage. But I think that's the issue that would be good to get into in the next discussions, the next level of discussions.

MS. FINBERG: I thank you for mentioning that. I agree. I think it would be -- obviously I can't read this right now. But it would be really helpful of everyone could read this draft from the president's commission and give Alain immediate feedback about it,

whether you agree with or disagree with.

I'm not recommending this list of options that's on here. I was just trying to lay things out, although, I think it's pretty good. And we should follow a lot of this. I think we need to model it into what's appropriate for us, particularly focusing on California's needs that are helpful, unlike what I was able to do, and provides a much more comprehensive structure and lay out issues for people that are very interested in this issue. If you can mark it up or write a separate document responding to this, that would be helpful.

MR. LEE: One other last point, the other thing about comment on standardization, standardization is really in both areas. One standardization of data collected, it should be standardized not duplicative. There are important benefits to standardized communication to enrollees. I don't want to discourage renovation.

In the area of disputes, it's one of the things that gets very confusing. Everyone communicates differently about it, and consumers do change plans. And by having it, different people can get more lost as they move around in different systems. I think we need to rest with standardization on both levels.

MR. ZATKIN: I think we need a baseline. Maybe that is what is currently required in terms of information. And then by law, in Knox-Keene and then what is available to part of the population because they are part of PBGH plans or this system in CalPERS in order to

say, "Well, what's additional?" I know there have been some bills considered recently that would have added additional elements, and it would be helpful to kind of know what those elements were. There was, I think, the Rosenthal Bill that would have provided for substantial disclosure, you know, just in terms of considering this issue.

MR. GALLEGOS: First off, I just wanted to say that this clearing house, whatever it would be for all this information that we're proposing to gather could be an outside organization as well as a governmental agency, couldn't it?

MS. FINBERG: Yes.

MR. GALLEGOS: There could be a group out there who could serve as the central database for compiling all this and putting out some kind of a report and advertising it to the public that this is available.

MS. FINBERG: Sure. Give it to the consumers union, for example.

MR. GALLEGOS: Well, I didn't give any names.

MS. FINBERG: I wasn't recommending this option necessarily. I really was trying to lay out options, and you're right. When I put agency or entity, that's what I had in mind. It could be a government entity that was created, or it could be something that already exists, and it could be nonprofit or profit, et cetera.

MR. GALLEGOS: Okay. Thank you.

MS. FINBERG: Ron.

MR. WILLIAMS: Two comments. One regarding standardization, and it's something I kind of always worry about in the mind, henry Ford said, "You can have any color you want as long as it's black." I think there's a difference between standardization and standards. I hope as we have the debate, I hope we talk more about standards as opposed to standardization.

People have different needs, stages of life, financial circumstances. And to some degree, products that are successful in the market recognize different needs people have. And I think standards is really what we're talking about so the consumers can be sure they're getting something that meets certain established guidelines that the legislature and society feels are important.

Second issue, I think one of the costarring points we have to grapple with, our plan grapples with it, I suspect all others do too. This is a category of service of something that is low involvement, low frequency of use for most consumers, and we can have mandates on information. We can make all the information available. But one of the things we need to work on as an issue is to get consumers involved more on the front end in really understanding the choices and the options.

I think Alain said it best. Most people leave their plan after they have a need to utilize it.

And at that point, the utilization has been made, and it's a little late in the game. So I think one of the things that we can contribute to is matching the plan selection to their real needs, and all of our research says low involvement category, and most assume it's low in frequency usage.

MS. FINBERG: Well, that's really a good lead in. On the second part, I don't know if we're quite done. Ellen is going to be presenting on the involvement side, which we'll get much more into detail on that. Yes.

MR. ZAREMBERG: One final observation. I don't know if we can look at it, if marketing research has ever looked at it. Your small and medium size businesses make a lot of the decisions for the consumers, and when we talk about getting consumer information how do -- you know, consumers might not -- the consumer may -- I think there's two aspects of it.

We talk about the need to satisfy grievance procedures. Let's say that's one aspect of it. And that may be at the back end after you have a problem. How do you choose a plan based on what you perceive to be meeting my needs, my quality?

I want to pick a plan on quality that's at the front end. That may be a decision that the consumer makes or the employer makes in conjunction with the consumer or the employer makes all by him or herself in conjunction or consultation with their agent broker.

And so if there's data that you're directing

only towards the consumer, who's the user, this information may never get to the person or entity that actually is in the decision-making process to purchase the plan. And so I don't know. I think maybe we need some discussion or some insight into how agent and brokers take this information that has been pointed out, CCHRI put together. Do they help small and medium size businesses? What information do we use? And how do we get that information in their hands so we can make a decision that helps both employers and consumers.

MS. FINBERG: Right. Well, I think that we are -- the marketplace is moving towards assisting employers in making their decision, and the Pacific Business Group is a good example of that. I think that the initial decisions were based on price, and now there's more information of more varied types that are collected and given to employers. The problem that I have is that employers are not necessarily poling their consumers and getting the information that is relevant about usage, and one of the reasons is it's so hard to get that information.

So what I'm concerned about is developing information that isn't as dominated by the employer. And you're right, you know. We're not as developed on the small and medium businesses as we are in the big ones, but I really do want to look at the consumer. Or you could call it the employee in most cases.

And big businesses that have a human

relations department may have the capacity to start receiving that information as there's more awareness and knowledge that the consumers have to give feedback about those choices, but I feel like that's really where we're at, the infancy, and someone should be providing more information.

MR. ZAREMBERG: I think there's an answer to Alain's question. I think at the right time I'll explain.

CHAIRMAN ENTHOVEN: I think we better move on to Ellen in the interest of time here.

MS. SEVERONI: For my aspect, you have a handout. And that should be two pages with the first section being consumer values. And I don't think it will take me too long to set up this whole area of consumer involvement. And in some ways, I feel saddened about that.

13 years ago, as some of you know, I started an organization called California Health Decisions, and the goal was simply to involve the public so that public values could be incorporated into policies and practices.

And I'd have to say that in preparing to lay out for you some models of consumer involvement, there's probably as much a girth today of consumer involvement in health care decision-making as there was 13 years ago. And one could look at that as maybe an indictment on CHD a small non-profit organization in Orange County. Or maybe you would have to look more careful at ourselves.

And I guess if I went into this conversation

with any bias, it is that I think in the industry we are going to need strong incentives to promote the kind of consumer involvement that I think will essentially create the kind of quality in managed care that all of us are going to see. Just to lay out some examples of what I would consider consumer involvement, one would be the system up in Washington.

And obviously there's a relationship there between Kaiser Permanente and group health. And, Steve, you could share with us more than I can the involvement. The governance especially that consumers have in that kind of model. That's not the only one, but I think the best one to demonstrate. And there are many.

The second would be there are two other involvement mechanisms that I shared with the group at Fresno during my presentation. One is the use of a member advisory committee at Cal Optima in Orange. Cal Optima was involved in the design of that system and the organization and the board of directors in the on-going quality assurance mechanisms, including grievance procedures, as well as the evaluation of how that plan serves it's members.

So it's a very, very integrated and involved member advisory committee. I would say ombuds programs like the kind that Peter mentioned could share a lot more with us about our other good mechanisms of consumer involvement. And again, I would say across the country, they used very little compared to how well they could be

used.

Finally, feedback model that have CHD has created with providers and health plans and purchasers to improve quality and consumer driven process of involvement. That's not very many.

13 years ago accident, my biggest hope would have been if I was standing before you today, that at the very least, each one of us could look at any plan in California and identify five. Minimum five processes or structure. And each health plan that each purchasing group used and each provider network that were specifically designed like the ones I've just mentioned to involve on-going consumer input and design and implementation and evaluation.

So I think just five would be -- and this is just very biased and my own starting point for discussion. I think should be the minimum that we should shoot for. And whether that can be done through public or private incentives, it will be up to my colleagues to discuss.

Any conversation around the consumer involvement I think needs to start with consumer values, and I won't take the time to walk us through the seven values that are on your first page. These are other values CHD has heard over and over again when we are working with consumers. These are values that people use when they're sitting around the kitchen table or when they're in one of our public forums to think about what some of the trade offs are in health care choosing and

what they're willing to do to move ahead.

For our discussion this morning on Page 2, following Jeanne's dissertation about separating this into principals and recommendation, what we've been trying to do, and I want to thank Alain's office, in terms of recommendation for changes in consumer involvement in the health care system, is it must be based upon a redefined guide principal. So we've laid out the following principals to serve as a jumping off point in our discussion about the principals around which the task force can develop a consensus.

So the first one would be member patient involvement in managed care decision-making, including member participation and product design, development of marketing materials, design and grievance procedures and quality improvement processes, well-improved managed care quality and enhanced consumer service and satisfaction. Any takers?

Is it more likely that people would disagree with a principal like that? Are there people in the room who feel confident that a principal like that should guide the deliberations we make around recommendations? I'll go through all four of them.

CHAIRMAN ENTHOVEN: One wonders why isn't that happening, or is it?

MR. WILLIAMS: I think it is happening. I think it's a matter of degree. I think that there are formal regulatory processes that require consumer

involvement. I think also plans who are trying to win in the marketplace are very interested in hearing from the customer. You want to design products that consumers like and meet their needs. I think it's a matter of degree and opportunity for advancement. And in what we're doing, there's clearly work for improvement.

MS. SEVERONI: What processes exactly are you talking about?

MR. WILLIAMS: I'm talking about focus groups. I'm talking about formal member advisory committees in which members are presented with new product designs, provided information on grievance processes, and types of issues that members raise, and ideas are solicited for how to improve those processes. Those would be just some specific examples. Opportunities for members to review new brochures, things like that.

CHAIRMAN ENTHOVEN: Steve, does Kaiser Permanente have member advisory groups that each --

MR. ZATKIN: We have them in some areas, not all. We do use focus group. But I think there's room for more of this. The issue in part has to do with how much involvement -- out of five million members, how do you involve those who are most interested and still move your activities forward and not have them just sit.

MR. ALPERT: I think this is a great area for discussion, because the ultimate number of patient involvement in managed care decision-making is the time when a patient or member can have the care that they're

trying to have or wondering if they can have and so forth.

And as a physician who sees patients on a daily basis, I was just trying to think if I ever in the past several years have seen a patient who was frustrated or had an enigma or a vague area about the carrier, whether it be diagnostic or treatment, where they called the company and came back and said, "Joe, you know, they have this wonderful process for me to avail myself to figure this out."

I have no memory of that interaction at all. And the ultimate help a company could give to a member or patient in decision-making is explaining that. People can accept certain things if it seems that it's fair and balanced. But that's the most important member plan interaction. I think that's when they're the most vulnerable and it seems to be the time when they get the least satisfaction in terms of information.

MS. FINBERG: That's where the ombuds model helps at that point when there is a problem.

MR. WILLIAMS: I think perhaps one example that I could come up with, some plans have access to nurse advisors who are available 24 hours a day. Someone is contemplating a particular procedure. They can call up that nurse and really get feedback and guidance. The person has an axe to grind one way or another with whether the person gets a procedure or not, but the nurse can provide some context for understanding.

So I think that there clearly is a long way

to go. And I don't want to suggest there is a significant opportunity for improvement. But I think you'll find that more and more and more is going on perhaps in different plans in different ways. And maybe one of the things that you might want to think about is what can we build on in regards to those areas.

MS. SEVERONI: I'm not hearing anyone say this could be a principal group we could embrace.

CHAIRMAN ENTHOVEN: Right.

MS. SEVERONI: The second principal, consumer involvement mechanisms, consumer feedback groups, focus groups, member advisory committee, an ombudsman program can improve the overall efficiency and marketing of plans and medical groups.

Again, what I'm look for here is, you know, is the task force able and willing to embrace this as the principal to guide further recommendations?

MR. SPURLOCK: One thing that strikes me about all these recommendations and all these comments is it's looking at the consumer in the abstract. And I think that's very valuable. I think when you look at population based health, you have to look in large abstract terms. But I'm thinking about consumer involvement on intimate decision-making process about their health care. I'm thinking about the one-on-one relationship in the office, what we do in our organization. We have to think decision-making starts in the home.

We give books out to all consumers that are

members. They have an opportunity to look at this to see whether this is care they want for themselves. I'm thinking of those kinds of involvement as being more important -- not more important, but equally important as the advisory panel as a group.

I'm all for those, but I think we can't lose that focus of what can go on in the office on the individual's level, maybe in the home after the care is gone, when they're leaving the hospital, and all the different venues so that the patient is constantly a component of the decision-making process from start to finish.

MR. RODGERS: I think implied in the involvement issue is taking this down to the next level, which is the group practice, very large groups. Is it your intent in your principals to cover that level, to leverage the plan's contractual relationships to say this should also be embedded in your contractual relationships?

MS. SEVERONI: Certainly the intent is to recognize that a lot of care is delegated to the plans. A lot of this has to focus very much with the providers, yes.

MS. SEVERONI: I think the last principal does get to that a little bit. And we go to provider organizations as well as purchasers.

MR. RODGERS: Do you see this as kind of a regulatory mandate or an encouragement and contractual mandate? What's the mechanism to assure this happens?

MS. SEVERONI: Well, I certainly don't have the answer there. I'm hoping that the group will help us think that through. But I'm not ruling out the strongest kind of incentive. I hope it can be primarily focused on private incentives.

When I look at how poorly we've done thus far, I don't know what it's going to take. I think Alain's question, "Aren't we doing this?" Yes, we are doing it, but everyone agrees, it's not just a little bit better, but we must do an extraordinary job of improving it. I think we're going to have to make some tough decisions about what it's going to take to do that.

MR. GALLEGOS: First off, on this consumer information, I'd like to make a clarification, if we can. What I see is that there is a distinction here that we need to make clear. There are two levels of information.

There's advertising, which is one thing. I mean, that's, you know, the 30-second commercial that says, "Our doctors are trained at Harvard. You should choose our plan," flashy brochures, colors, no deductible, no copays, free prescriptions. I think that's one level of information.

But I think it needs to be distinguished from the information that's provided for patients to make the choice of plan so that, you know, it's one thing to attract potential consumers by your, you know, commercials and your advertising materials, but I don't think that's really the information the consumer is going to use to

ultimately make the decision.

That information is going to be, you know, how are they on annual pap smear, physical exams? What's the formulary? Sure, okay, free prescriptions, five-dollar prescriptions, but, you know, what medications do they cover? What medications don't they cover? How does one's plan for treatment for diabetes differ from another?

I think that's a different level of information. And I think we need to make a distinction between, you know, consumer information and then what -- focus groups will tell you, "Yeah, I like that commercial. Gee, that's great. The doctor looked nice. She was very professional. Yeah, she's trained at Harvard. That's pretty impressive."

But another kind of focus group -- and I don't know if plans do this for that other level of information of consumers looking for, like, the ones what I described that are more particular and specific.

MS. SEVERONI: I think it's a dead distinction, and we can certainly move it back into the consumer information side of things. I would tie it into the consumer involvement. I think if plans and provider groups and purchasers were spending more time and energy in true consumer involvement, we would go beyond those initial focus groups and go much deeper and listen more carefully to what the consumers are telling us.

And I think we probably would be able to

spend much less money on the advertising because a broad stroke look at recent surveys can tell me that most people make decisions about a health plan by talking to colleagues at work and family members. So extraordinary dollars are spent in the advertising arena.

If I were running a company, I might move someplace else, because retention and consumer satisfaction is much more important.

MS. RODRIGUEZ-TRIAS: I come from the days of the mandated consumer in the public system throughout the community health centers and the public hospitals and so on, and had a great deal of experience with some of this.

And one of the things that I've seen very common was the issue about information, the training, the time, the supports for that, you know, that there has to be -- well, have to be actually commitments. There has to be a commitment that supports the consumer participation in all its levels, because what it usually turned out to be, the professionals took over no matter what, even if 51 percent were consumers because they control -- were the ones who knew the technology, information. I think there has to be really a true commitment. There has to be some kind of commitment and support for this to happen.

MS. SEVERONI: I think we get to that in one of our recommendations when we talk about collaboration among government foundation plans, provider groups, and purchasers to fund development of consumer involvement

programs.

MS. FINBERG: Peter has been trying to get your attention.

MR. LEE: We're sort of jumping around here. We're commenting on recommendations as well as principals; so I felt a little out of place. I want to come back to Dr. Alpert's point.

The important point that I think is worth incorporating as an additional principal in acknowledging that one of the principals involved in this is that people are involved, patient involvement with provider, practitioner. A lot of these recommendations and the framework is the system level, which is important.

But I think the first principal point, and it's what a lot of the ERGs and a lot of our discussions are try to get to in different ways, so it's not only here, but developing that idea. I think it's very important. I take it as a friendly amendment.

Consumer involvement needs to first and foremost be, we have to have the systems in place to foster that relationship to make sure the patient is totally involved in that clinical decision-making, is informed, there's not barriers, et cetera.

And I want to sort of follow-up on that point. If I heard it correctly, the other -- I'd like to echo very strongly the point relating to a lot of the recommendations that participation, to be meaningful, really needs to be supported.

To say someone can be involved at the table doesn't mean they have the information to be an active participant. And I think Ron's point is an important one, that Knox-Keene requires that HMO's have consumer participation. How it actually comes through, what little I've looked at, it's very mixed, it's very inconsistent between plans, how they incorporate consumer participation in policy-making. How much consumers get support. How much they really know it's really there.

And the third point, add in a consumer involvement mechanisms survey. What essentially we're talking about, quality measures, how are the standards without surveys that are -- that get at information to inform the whole range of players to improve the system. And I think surveys are one of the ways, as well these others that we need to acknowledge as vehicles to actually hear from consumers.

MS. SEVERONI: Principals, strong public and private incentives are necessary to ensure the health plans develop organized systems of consumer involvement and advocacy. And I would include health plans and provider organizations there. I would amend that. Taking your point, Tony, we've done that.

MR. WILLIAMS: One question, if I may. I'm curious, do you believe that the plans that apply these principals would be more effective in recruiting and retaining members?

MS. SEVERONI: Well, I think if clearly the

information gets out to the public, I do, Ron. I think -- I think they will be because I think by listening to -- I don't know another industry in the United States that doesn't listen to its customers and continues to improve processes based on that input.

And I think the health system dabbles in it. I think we dabble in it, but we are not committed. We are not committed to consumer driven processes for quality improvement. And I think that those processes will enhance your services and enhance your ability to compete and most importantly give patients and their families the care and service that they need.

And that doesn't mean that they want -- I really separate that out, because I think consumers have a very important roll in here. There's a shared responsibility for health and for -- even for the health of the population, and as we become more involved as members, I think we use that word "member" all the time, yet I don't remember the last time that the criteria for membership in my HMO were made very clear to me. That I was valued as a member, that there were the processes for engaging myself within that organization. Sort of the whole aspect of what membership means, it is a give-and-take. I'm just not taking all the time. I'm expected to give. When I give, you listen.

Right now what I hear from consumers who have been surveyed to death, is I can't get a single person to tell me once an improvement was made, no one

could tell me that my input was valued and something changed as a result of that. I'm really not overly criticizing. I'm just say, I don't think we have done this with the kind of gusto that would clearly show on your bottom line that this was worth doing.

MR. WILLIAMS: I guess the point I was making is if marketplace performance would improve, if people do this, and it becomes the voice of the market saying this is what consumers, your plans will grow. It will do better. You will have more members to serve. It seems to me that's a pretty good incentive.

MS. FINBERG: What I'm struggling with is the abysmal lack of these kinds of measures without. At this point, the consumer is sovereign when picking a plan. But once you're in, that's it. You really don't have the kind of mechanisms to be able to improve your relationship with your providers, with your plan. I know, Allan, you had something.

MR. ZAREMBERG: Can you give me some examples of what you mean by strong incentives?

MS. SEVERONI: Yeah, I think one strong incentive from the purchasing side, for instance, is something I experienced a few months ago when the Pacific Business Group on Health in a contracting relationship with Health Net accepted their first go at a contract, and said, "This looks good, but we want consumer feedback in there before we sign on the dotted line."

I consider that a pretty small incentive

from a purchasing organization saying that they wanted to see a very specific consumer involvement mechanism in place in order to put a contract in. I think that was pretty strong.

Another kind of strong incentive would be an incentive that came from the public side that said that we would have to have at least five mechanisms of consumer involvement in plans and medical groups demonstrating by X-time in order to meet Knox-Keene.

MR. ZAREMBERG: Can I ask Ron, because of your empirical evidence, and I appreciate that, because I think that's what you do very well, but Ron and maybe Steve Zatkin and anybody else in your plan, in your focus group, has certain consumer information made a difference in the retention plan so that we make sure that people get the information that is most important for them when we're discussing this?

MR. ZATKIN: I don't know the answer to that. I do know that I'm not involved in some of the operation side. We've had one experience which is instructive. It had to do with the clinical area where we -- there's a generic task for breast cancer. And, you know, Bruce can describe it more accurately than I.

But normally, we would have just developed a guideline, internally. And in this case, because of the fact that we think that patients are more active in their concerns, generally, and because we thought it was the right thing to do, we went out to patient groups across

the country on this one and listed a lot of input.

And I don't know if we have better guidelines or not. I know we have groups who feel better about the guidelines. So that's a fact that is hard to measure in general. And I don't know how to translate in terms of member satisfaction down the road, but I think it's a very good model, and I'm hoping that we will pursue it more broadly.

MR. KARPF: I have a little concern. Does that mean appropriate care becomes a matter of consensus of the public as opposed to a matter of careful investigation and evaluation by physicians, whoever else needs to be involved? I think we've got to be very careful as to how we decide what's appropriate and not appropriate. We've got to make sure that even within small decisions, if we set a precedent, it will come back --

MR. ZATKIN: I think it means that you're prepared to explain the basis for what you're doing and to listen and get input.

MR. KARPF: That's different than making it a count of votes. Because I think there will be a lot of areas where there will be considerable disagreement.

MR. ZATKIN: We didn't do a vote, but we went out and did talk with groups who did have a strong interest.

DR. ALPERT: This is a different topic. I appreciate Steve bringing it up. I think BRC for breast

cancer points out an immense paradox in goal consensus, population based consensus that Michael talked about and Bruce talked about.

If you get a sense now from breast cancer fundraising organizations in the country, from large groups of people that opine on whether tests are good, bad, or indifferent, what's happening now, and you're going to see much more of it, is that the science behind breast cancer technology is excellent.

The information that is potentially available to people is unbelievably profound in terms of what their predilection for getting a certain specific illness might be. The overwhelming theme surrounding this now in terms of whether people should or should not have it done in the public in the overall large consensus group are that, do it, don't do it.

There's actually advice, be very careful about this, that reason for that is that you will be discriminated against somewhere in the future, most likely by an insurance company of some nature. It might be job discrimination, health discrimination.

And that's a very, very pronounced phenomenon going on. It's recognized by the United State Senate. And it's a paradox, because we're developing profound information, but the country is being -- by consumer agencies, people are afraid of what might happen to people, advising people against getting access to profound information. And that's a paradox.

CHAIRMAN ENTHOVEN: Excuse me just a second. We're running quite a bit behind. I hate to be approaching cutting this off, because I think this is a wonderful discussion we're having, but it's now 11:19. Could we aim to say end this by 11:30, because our next speakers have time constraints of their own.

Ellen, you're doing a wonderful job here. And I hate to say that.

MS. SEVERONI: I think the task force input has been fantastic.

MR. SPURLOCK: In medicine there's a lot of uncertainty, there's a lot of medical uncertainty. And whenever there's a great amount of medical uncertainty, the patient's values becomes much more important on how you proceed. So if there's very little uncertainty on pneumonia on using antibiotics to cure pneumonia, it's involvement is important, but probably not as important whether a woman has a mastectomy or lipectomy because of breast cancer. There's a huge amount of uncertainty in that issue.

When we develop guidelines and develop clinical interventions over great medical uncertainties, which science can't solve or the system doesn't know the right answer, I think that's when the computer needs to be closest to that decision process.

They need to be intimately involved and understand that. We need to understand how values play a role in that clinical decision-making when there's great

uncertainty. We're talking about breast cancer and those issues, where there's tremendous uncertainty, and I think that's where we need to have consumer involvement the greatest.

DR. KARPF: I think that can be taken one step further. If we look at the breast cancer patient who's either going to have a lipectomy or who's going to have a modified radical, we at least know that there's some kind of surgical procedure that's going to be indicated.

But where we get into real problems is where there's total uncertainty in the efficacy of the procedure. For example, a patient has unusual malignancy, and someone suggests bone marrow transplant. And there's not much data. And there has to be a mechanism for resolving that because that can't be a mechanism that's based strictly on a desire. There's has to be some kind of resolution process that deals with the issues of scientific basis value. And that, I think, becomes a critical area for us.

MS. SEVERONI: It seems to me we got less than ten minutes to discuss recommendations. I think it might be worth trying to quickly move down through these recommendations so that we could hear a little bit more. The first one being government purchasers and plans should develop and implement formal consumer feedback mechanisms that result in useful measures of the extent to which the plan and their provider group is successful in involving

consumers in organizational design and decision making.

If I can read correctly, what Martin and I are trying to say here, I think what I would be saying to cut to the chase, is that we are evaluating involvement and improvement mechanisms based on what the consumers think is improving here.

In other words, the kinds of mechanisms that we would use to produce useful measures would have to be measuring whether or not the consumers think we've made improvements so that Ron or Steve, if you're involving certain consumers in an area of breast care, you would go back and evaluate changes and improvements that you've made with those members to see whether or not an improvement has been made and was valuable.

MS. BOWNE: Ellen, I'm sensitive in making this comment, but you could have very happy but very sick consumers. You know, good bed side manner does not necessarily equal good care. So while I'm sensitive and I absolutely applaud these efforts to involve and to sensitize and to have more consumer involvement, I think, you know, at what level and how, and how is that measured, I don't think at least I could buy off on this at this time.

MR. WILLIAMS: Ellen, I'd be curious how this differs from the measurement process that health plans would use with the NCQA accreditation process where you're asked to survey your membership to solicit inputs, to show quality improvement in the feedback that consumers

have given you regarding access, clinical services, et cetera. How would you differentiate what you're proposing from the fundamental aspects on quality preservation principals.

MS. SEVERONI: Well, for one thing, when I look at the NCQA standard, I've yet to have a room full of consumers who really fully understand what it is NCQA is asking for. In fact, I know they've begun to do some consumer focus groups in terms of the accreditation measures that they're asking for, but I don't think they've done nearly enough for me to think they're hitting on the kind of a model for improving quality that is important to consumers.

I don't think at this point that health plans or providers are collecting information enough that has been driven by putting that information into consumers' hands. So what I would be suggesting is that while I know at this point you've got to comply with those kinds of NCQA standards that you want to be able to say to purchasers that you're meeting a specific set of quality standards, those are still driven by purchasers, and they are not driven by consumers.

I have yet to see at this point where the purchasers were large employers are looking far enough beyond cost into the quality issues to suggest -- to be comfortable there. So I think that the kinds of consumer feedback mechanisms that we're talking about, I guess, would be more local and would respond to a need that many

consumers had to know how other colleagues and consumers measure the plan.

MS. BOWNE: But that comes up through the -- not necessarily individual, but through the employees benefits mechanism. And certainly if they're getting complaints about either the access to service, the type of service, or the quality of service, that is clearly an indicator that will be brought up by the employer in the health plan, whether it's a small employer who is himself or herself the business owner who hears from their employees that they're unhappy or whether it's an extremely large employer, such as a CalPERS type of system.

And I think that there is a mechanism there that does involve consumers. And I think it's rather unfair for you to be damming the whole industry in effect by saying no one has consumer feedback groups.

Now, they could be more systematic. They could be more intense. They could be measured. We could come up with particular areas where we feel that this is an overriding concern. We would like all health plans to incorporate these particular measures. But when you're speaking generalities of consumers and that huge complex field of health care, without giving it more specifics, I think we're going to spin out the wheels and not get anywhere.

So I want to convey I think we do need more consumer involvement. So I'm very sensitive to that

issue. But I think if we leave it in this amorphus, do more good things, we're not really going to get very far.

MS. SEVERONI: What would one specific thing be that you would put out there that we can do to improve?

MS. BOWNE: Well, one that I can pick up on, certainly some consumer testing of the information that goes out. And I do think, if I'm not mistaken, that like in Medicare and some of the other programs that are required that people could at least understand what is trying to be communicated, does it achieve its purpose, for instance.

MS. SEVERONI: So that would differ somewhat, I think, Ron, from the NCQA standards?

MR. WILLIAMS: I think it does. But I think one of the issues that you're really crystalizing as I hear you talk is the real dilemma that we face between what I'll call clinical quality versus marketing quality.

But I think it goes back to the comment of consumers feeling good and certainly feeling good about the health plan, from what I think is a great idea. At the same time, if you look at the NCQA types of process, they're really asking have you fundamentally improved access to specialists? Have you done things that result in your members having better access to clinical services and hopefully better outcomes as a result of that.

And I think one of the decisions, all this costs money. All of this represents a tough trade off. And I think that those are some of the things that will

have to be debated.

CHAIRMAN ENTHOVEN: Ellen, I think we need to approach kind of wrapping this up. I regret this very much.

MS. SEVERONI: I think the conversation was very, very helpful. Okay. I think at this point, I would encourage individuals who would like more to say about the recommendations that we've laid out here to contact me and Jeanne, and I'd like to talk with you some more, especially about the specifics. Becky, I think your point is an excellent one.

We, at this point, just didn't feel that we could get as specific, I think, as the group would like, to hear more about. So I'll turn that back over to you.

CHAIRMAN ENTHOVEN: Thank you very much, both of you. I think that's been very interesting. And I want to thank all of the task force. I think this is one of the best discussions we've had.

Next, we're going to move to discussions and presentations on risk adjustment and standardization of health benefits packages. These are very important issues and problems. And we're blessed by having some of the nation's top experts on these fields.

First, we're going to have a presentation by Professor Harold Luft, Director of the Institute for Health Policy Studies, and Professor Health Policy and Health Economics at the University of California, San Francisco. Dr. Luft is one of the very few topmost

respected national experts on this topic.

We'll also have Sandra Shewry, Executive Director, Managed Risk Medical Insurance Board. Ms. Shewry's distinction has been to be perhaps the most courageous person in taking the lead and putting risk adjustment into actual factors in working through those problems.

And then we have a present by Dr. Linda Bergthold, who is a health care consultant, who has played a leading role in the standardization of benefits packages.

What I'd like to request of the task force is that we have these three people present first before we have discussion, because some of them have time constraints. Then after they have presented, then we will be able to have a more general discussion.

I'd like to thank the three of you very much for coming and sharing with us your expertise. These issues cut across many of the other concerns we've expressed. We discussed risk adjustment enough now that I think everybody appreciates it's very important. We'll talk more about standardization. Thank you.

MR. LUFT: Thank you. I'm pleased to be here. And I think the preceding discussion actually served as a very useful segway into this discussion, and hopefully will provide some answers to some unanswered questions.

I'd like to begin with a bit of disclosure.

I've been in California 24 years. I've been in eight HMO's. I've been involved for two years at UCSF on the health benefits subcommittee and welfare committee.

And what got me into the issue of risk adjustment was an experience of a little over a decade ago. We were hearing that employees who had been newly hired at UCSF, and we've got uniform benefit package, free choice, no pre-existing condition process, et cetera.

They're going to see their doctors, and the doctor said, "You're not enrolled in the health plan you said you were." "Well, I filled out the forms, of course, back and forth benefits office." And then the health plan said we never got an enrollment plan. We've never charged you a premium.

Well, it turned out after a little bit of investigation most of the people whose paperwork was lost, I'm sure you've all had paperwork lost, were single male employees who lived in the Castro District. So it's real clear what was happening. Legislation wouldn't have fixed it. That health plan is not in business anymore due to other factors.

But the point is it led me to start thinking about how do we get health plans who want to take care of sick people? How do we get them to want to be the very best place to take care of women with breast cancer or of risk to breast cancer? And that's a different issue. And I would argue risk adjustment needs to be addressed.

Risk adjustment gets used in a couple of

different ways. Thursday I was in a meeting with Dr. Werdegar, with his other hat on, AB524, we do risk adjustment to try to produce reports for the state of California on differences in hospital outcomes, adjusting for differences in patient risk.

Here what we're talking about is risk adjustment, adjusting for differences in enrollee risks that might account for higher or lower expenditure in a health plan. This is important because in a given year, about a quarter of any population won't use any medical care or won't use anything above the deductible. About 1 to 3 percent might account for 30 percent of all the expenditures.

You can imagine, if you're a health plan, which type of person you'd like to have. You'd like to attract the low users, and you wish the other people, that one or two percent, would be in somebody else's plan so that you don't have to deal with them.

Now, there are a number of different aspects to risk. One is the risk of occurrence. The probability may vary and often unknown. Like the probability of birth. We know genetically that women are much more likely than men. We know that there other factors, marital status, age, prior number of children, when woman had her last child will all be probabilities that will increase or decrease the likelihood that she might have a child in the next year.

The probability that that child is a very

low birth weight also has some risk factors attached to it, but it's much less important, much less predictable. Then there's the risk of the need for medical care -- the amount of medical care needed given that an occurrence happens.

The woman is going to have the baby. Does she need to have bed rest? Is she delivering early? Does she have to have a C-section? That is going to affect the amount of money that she's going to spend. And finally there are a series of things that are controllable. Do we discharge 28, 48, how many hours, et cetera? Those are discretional things.

What you'd like to be able to do is hold the health plan responsible for those things that they can control, and not hold them responsible for things they can't control.

If they happen to attract a lot of women who are going to give birth, then they should get paid more. Not the women paying more, but the health plan paying more. There has to be some sorting around of the dollars in the background. That's what large employers do. That's what the HIPC does, you'll find out.

What we need to do is figure out ways to adjust the payment to the plan to reflect the differences in the risk that they can't control. Now, one of these measures work terribly well, but none of them work very well at predicting the expenditures for an individual.

God doesn't whisper into my ear and tell me

this person is going to be $563,000, and somebody else is going to be $480,000. But you can predict that groups of people will be relatively high cost, and other groups relatively low cost.

Communists only figured it out in the last ten years. You can take care of these things with large numbers. And with large groups of people, it's not a problem. We didn't have a risk selection problem until we started having people with choices in different health plans. Because within a population, while the population risk can be predicted well, it's very hard to predict who's going to go into health plan A versus B versus C.

People might be excluded from a plan. You can get rid of that if you're a large employer, if you've got a HIPC type arrangement. But there are other subtle things you can't get rid of, the health plan I started out my discussions with or one that has, you know, absolutely wonderful benefits, but you have to get their prior approval, and it's almost like needing them to march up to God and get the approval.

Now, what happens that if you've got a chronic condition, next year you switch to another plan where you think you may not have as much trouble. It could be that everything that's covered in the formulary, but it's very hard to get the approval. Or it could be that there's subspecialists listed, but appointments take six weeks to get. And you can't get the subspecialty that you want. It could be the reputation. It could be the

location. If I were a health plan, I probably wouldn't want to have a lot of sites in the Castro District because guess who I'm going to enroll? So I locate them elsewhere.

Now, what you'd like to be able to do is develop risk adjustment models, statistical models. Don't worry. They know how to do this stuff. There are a number of different flavors, we can talk about them if you want, in terms of the different ways in which you would account for the different risk.

In the past, we had the feeling that these didn't work well enough, the artware, the percentage of the variances is relatively low. It ranges now from about four percent to ten percent. This doesn't sound very good. But in fact, it's not that bad, because a large fraction of the risk that one is for -- the expenditures that one is trying to explain are truly random. Patient gets hit by a car. Or the probability of a low birth weight baby given that a deliver is going to occur. That's basically random. Law of large numbers will take care of that.

What you want to be able to do is predict those things that are predictable. You want a model that that can explain the predictable variabilities and expenditures. And that's roughly 20 percent. So if you can get close to 20 percent of the variation, if you can get 20 percent, you're doing pretty well.

Well, there's some models now that are using

counter type data. Data that is regularly available on an administrative basis to many health plans, but not all, that can explain roughly 8 to 10 percent of the total variance. In other words, 40 percent of what you're worried about.

Joe Newhouse in the paper from Health Affairs that just came out this month is recommending -- and he was with someone who was saying three years ago, we're not getting ready to do risk adjustment. Joe has turned around and said we're ready to do it. It's time to start growing.

It's important to note that there are a number of different issues here. Joe is focusing in his paper mostly on the Medicare population, which is different that what we're talking about here. Obviously, what California does for its Medicare beneficiaries is very important as well, but the Feds are going to control most of that in terms of risk adjustment.

There are different way it can be implemented. Some of it is risk adjustment on a totally perspective basis. Some of it may be on a concurrent basis. I'm working on a proposal right now to say let's identify the small number of conditions that are likely to be very high cost and subject to selection, patients with HIV disease, cystic fibrosis, women with breast cancer who need long term follow-up, et cetera, and pay health plans extra to take care of those people. Pay them on a monthly basis based upon the level of risk within that category

for an HIV patient who CD4 level and viral load, as those vary, payment levels might vary. And this would be based not on claims data, which then allows you to flip that database around and say how well are these patients doing in terms of quality of care?

And if you're paying your health plan an appropriate amount to take care of a patient with AIDS, they may actually enjoy being identified as the plan that takes care of those people best because they're now very attractive patients. They might need an extra $30,000 a year, even though it might cost them only $28,500 because they figured out how to take care of these people better than average.

All of a sudden, the people who you don't want darkening your doorstep are very attractive to you. And you'd be getting information that would be relevant to the consumer, consumers with those high cost conditions, and maybe also consumers who don't have those conditions.

Because right now, we don't see anybody advertising how good their quality of care is for the very sick people. There's a colleague of mine who does risk adjustment who knows that risk adjustment models are doing well enough so when we see the advertisements, the billboards of the patients in wheelchairs saying, "This is the health plan I want to be in."

Now, I'm not worried about getting old very quickly, but I am worried about, you know, what if some catastrophe happens? What if I have a major accident?

I'd like to be in a plan that has the reputation of taking care of their people well.

Back to the question about why we don't see a lot of consumer involvement. If I were a health plan, I wouldn't want to listen carefully to women who have problems with breast cancer and design my system to be very responsible for it because we'd go bankrupt very quickly. We'd attract them, and that would be a big problem.

The other piece I wanted to focus on, I think it's important to say, "What are the messages that we're sending out to the health care market place? Right now the message is flat premiums, not differentiated by risk. And therefore, if you attract high risk people, you're going to go belly up.

But there there's a small fraction of the population, two, three, four, five percent. You do a big survey. Who are the respondents coming from? Largely the 50, 80 percent who have very little contact with the medical care system. Things are just fine.

Think about the last time you flew on a plane. You probably focused on the quality of the food, the move maybe, et cetera, not about how the pilot did when they had the 10,000 foot drop because of air turbulence. You probably didn't experience that. Yet you might be very concerned and you might be very interested in having information about how well airlines do in those kinds of situation.

So the surveys don't pick up the kind of information you really want, and there's no incentive for health plans. I would argue right now to try to encourage those kind of surveys because it wouldn't be right and wouldn't be of interest.

Finally, I think it's important to say let's not wait for the perfect risk adjustment tool to be available. The technology is rapidly improving, sort of moving along about as quickly as computer technology. I live down in Silicon Valley.

One of the messages that would be sent, I think, by putting out a clear statement that we are going to start implementing risk adjustment, and the implementation will take several years, probably three, and that's what Washington State put in place when they said we're going to put risk adjustment in their health care coverage.

But if you put plans on notice that in the long run, the ones that are going to be winning are the ones who really take good care of sick people, and that in the long run, the plans that just make money by attracting low risk people and getting rid of high risk people aren't going to be in business, that gives everybody time to adapt, maybe change their system or find another industry to get into. And that would be okay as well.

And so risk adjustment from my perspective is not just simply paying plans fairly, but it also can establish the mechanism by which you can focus on improved

outcomes, improved consumer involvement, and really move the health care system toward having physicians and other health care professions do what they really want to do. And not to not be able to take care of their patients who really need help.

CHAIRMAN ENTHOVEN: Thanks, Hal. I think that's the best exposition of the problem I've heard.

Sandra, good morning.

MS. SHEWRY: I'm the Executive Director of the Managed Risk Medical Insurance Board. We run the health insurance plans of California. That's a small employer purchasing cooperative. We have about 134,000 subscribers today, and they are comprised of about 7,000 employer groups. I have a handout, and I'll try to follow it, but I'll also try to move quickly in deference to the time.

Hal did a really great job of talking about the distribution of subscribers by risk status. There's about a quarter of us who aren't going to use any services in any given year. And one to three percent of us are going to place huge demands on the health care system. Our Board wanted to look at risk and risk differences, and really there's three motivations for doing so.

One is to try to really put some controls in the system, to try to deter plans from selecting or marketing to the healthier enrollees, and we see legislative efforts to try to get at that in terms of fair and affirmative marketing laws. To protect plans that are

selected against by costlier than average group of enrollees.

This is a motivation for wanting to look at this if we want to have all different kinds of plans out there in the market, those that are magnets for the costlier members when you do something to help them stay in business.

And then really the third reason, and the one Hal spoke so eloquently to and the one that motivated our Board to want to be interested in this topic was really that we want to provide an incentive for health plans to specialize in treating people who are sick.

We want to feel confident that when we're sick, there's going to be a network out there that is really good at whatever the condition is that we have.

There are things about the HIPC that provide a lot of protection for risk segmentation, and these are really the pieces of the managed competition model guarantee issue and renewal. That means that anybody that comes into the small group market that HIPC operates in can buy a policy, use a standard benefit design, and we're going to talk about that a little bit later after Linda's talk.

We have annual ability to change between health plans, a level playing field for all plans. The rules are the same. And then we have fair and open marketing laws as part of the small group underlying regulatory structure. And all these things are designed

to keep plans from being able to segment risk. I always like to include these thoughts in a talk on risk assessment because risk assessment and adjustment isn't the only thing you can do to try to control risk segmentation. And our state has been a real leader in this area, especially in the small group market.

Of course the ability of health plans to segment risk hasn't been eliminated. Hal touched on these. You could set up a provider network that just is kind of mediocre. Obviously you'd never set up a network that bad. That would kill you in the market place. But if you really don't have any diabetic care specialists, when those people with diabetes go looking for providers, they're probably not going to select your plan.

Also, the customer responsiveness, you know, trying to get services if you are a high-use consumer, maybe the customer service lines are slower for you, maybe your issues don't get resolved as quickly.

And then marketing techniques. As Hal said, we don't yet see the billboards with people in wheelchairs saying that their health plan are really great. And then it's important to acknowledge that health plans aren't by nature evil. And these things don't occur out of malice. There's just some random maldistribution of risk that does occur and I believe will always occur. And so we have a responsibility to look for that.

Two aspects about purchasing pools actually make risk segmentation worse, and I think those of us that

are interested in nurturing purchasing cooperatives need to acknowledge this. One of them is employee choice.

Employer groups come to us in the HIPC. The average group has 10 employees, 18 people. And we say here's up to 17 health plans you can select from. Well, that individual choice, because of the way the system works and because of network differences, it could be that there's just something about choice that allows people that are sicker to gravitate towards a certain plan or certain type of plan.

And then secondly, I want to have the ability as a purchaser on behalf of all the members in the HIPC to be really aggressive with health plans about price. I think a totally rational response from the health plan community is to look at how they could cut on quality.

If I'm saying I want low prices, I know the members are going to move if you don't give me a good price. One very logical response would be for them to think about what's the cheapest way to do things, not what's the best way.

So again, that was a motivation for our Board to want to have a risk assessment and adjustment process because we never want to have to be held back on counting on price. But we feel we need to do something to balance that incentive to scrimp.

What we did is we got together with our health plan, invited their actuaries, their marketing

people, their medical and anybody they wanted to send and art of staff at the Board and then some consulting actuaries we've hired. We said let's figure out how to measure risk distribution, and then let's figure out how to select for it.

In the environment that we're in California, and this is a little different than national truths, our truth in California is we move to capitation a lot earlier than most places in the nation, and part of the trade 10, 15 years ago was health plans said to doctors, if you'll take a capitation fee, you don't have to tell us what you're doing every minute of ever day.

So we don't have a rich out-patient data set in California. We don't have a lot of health plans that can link their pharmacy information to the in-patient and out-patient information that they maintain. So one of the truths in California here is we had to look to in-patient utilization data. We have a data system for that. Everybody collects it. Everybody has it.

We admit this is a very big weakness in the HIPC risk assessment process, but I think it's reflective of the state of the art in terms of what health plans can produce. In th HIPC, we look at things that health plans can't provide for. We have very comprehensive reforms in the small employer market segment in California. And plans can price on age, geography, and family tier. The family tier means a single policy or a family policy.

So our risk assessment process looks at

three things. We look at gender. Health plans today can't price for the fact that when I'm in my child bearing years, I'm more expensive than Hal. But once Hal gets to be about 50, he becomes more expensive than me. And so health plans can't explicitly price for that. And so we say in our risk assessment, we're going to look at age stratifying gender.

Diagnoses, this is probably the most innovative part of our process. We look at 200 marker diagnoses. I'm going to tell you in a few minutes how we established those. And then we look at the number of children per contract.

In the small group market health plans, Kent priced for the fact that one plan may attract a population where there's six children average on a family contract. Another health plan attracts smaller size families.

Because this is a zero sum game and there was no money to make these adjustments between health plans, we look at the enrollment of the HIPC as a whole as kind of what's normal. So three factors gender, diagnoses, and a number of children per contract are always compared to what's the distribution of these in the HIPC as a whole, not to some bigger population norm.

I'm going to tell you a little bit about our list of marker diagnoses, because this is really the most powerful piece of the risk assessment tool.

What we did is we asked our health plan partners to give us their databases. We're very lucky

that three PPO's and HMO's that were participating in the HIPC gave us their entire utilization database. This is really a treasure. This is what we would all like to get on a regular basis. Most of our other health plan partners either don't have a rich enough administrative database that they could provide it or were unwilling to.

We basically gave this to a third party entity, a contractor, and we looked at all the utilization these health plans had for a two-year period. And we decided that any time a diagnoses resulted in average charges, and charges aren't what health plans pay. They're what providers say the cost is, because we think that's a more common measure. Because some health plans are very big and powerful and negotiate great rates for providers and some are not so big and powerful.

So we looked at charges. One was over 15,000, and there was a in-patient stay that said that's a marker diagnoses. Those are the kind of people health plans probably have an incentive, a fiscal incentive to avoid. And so we came up with our list of markers.

What we do is we basically look at distribution for each health plan of gender compared to the HIPC as a whole, the incidents of these marker diagnoses compared to the HIPC as a whole, and then the family size in terms of the number of children, and then we multiply those three factors together.

Now, are those the ultimate ways to assess risk? No. Those are the three that the health plans

participating in the HIPC, and they are the majority of health plans in our state, everything from a plan that serves a piece of a county in L.A. to a statewide plan.

This is what we would agree to that made sense to us that felt like it was fair and felt like it addressed the issue of risk distribution. Down there that slide that's marked No. 10 gives you the results of our first two years of calculations. We did do three simulations of this model before we asked our health plans to actually put their premiums at risk.

I'll help you interpret these numbers. 1996, the HIPC as a whole is a 1.0. That's what I mean when I say that everything relates to the HIPC. So if the HIPC as a whole is 1.0, we had a plan where the score was low as .92 and one as high as 1.3. So what?

So the task of the group was to figure out is that too much maldistribution of risk? Where one plan's got 92 percent of the norm, and the another one's got 31 percent. Our work group said, yes, that is too much, and we think that we should correct for that risk distribution.

I'll tell you how we did that. In '97, we saw less of a spread of risk maldistribution. We saw scores from .93 to 1.04. We asked our health plans before they saw these scores to agree on too much -- on how much risk maldistribution was too much, because we thought once they all saw their scores, their idea of what should be corrected and what was okay would be changed depending on

how their own particular plan score came up.

So before we showed them the scores, we had them agree, and what they agreed to was a plus or minus five percent corridor of risk maldistribution. The real risk adjustment believers, and I see a couple of them in the room here today, think that any difference in the scores means that you should move premium dollars around to make all the scores one.

But other health plans said, "Hey, this isn't rocket science yet. This is an experiment. You're talking about our premiums, and we're a little nervous that you're going to move money around. And so let's do plus or minus five percent." And so the work group agreed to that.

So that means that if those values I told you about, if they had all come out between .95 and 1.05, we would say the world is not perfect, but it's good enough for us. The distribution of our members in the health plans in the HIPC is good. It's fair enough.

As you noted from those scores, we had outliers in both cases. In the 1997 calculation, we didn't have anyone at the high end. That score of 1.04, that's within our threshold. So we didn't feel in 1997 that there was any health plan in the HIPC that was getting too much bad risk.

But looking at the other end, the .933, it had preagreed to a .95 threshold on the bottom. So we said three of our health plan partners are getting such

favorable selection that they're unduly benefiting, if you will. They have gotten better membership than the HIPC as a whole. And we're going to take some of their premium dollars away and move them to the plans at other end of the spectrum.

So while there were no plans that were high end outliers, we gave the money from these three plans, I listed them, we took dollars out of their premiums and gave them to the plans that had the highest scores.

Going to that slide that's marked No. 14, in 1997, we're moving a little bit less than one percent of the premium dollars as a whole. The range in terms of the premium impact on plans is a little under two percent to one percent.

On that slide, I do show who the receiving plans were, Blue Shield's PPO, Lifeguard, and Sharp. While our risk assessment tool didn't say they were being adversely selected against, they had the highest scores. And so because we had our Levin plans, we gave our dollars to those three at the top end.

How does it all work? It's invisible to our subscribers. We do this calculation in December of each year. We audit individually each and every incidence of a marker diagnoses. We tell the health plans before they negotiate rates with us whether or not they can expect to be a receiver or a payer of plans. We think that's only fair to tell them up front whether or not we're going to be taking money away from them or giving them money.

Our members don't know about this. We don't provide that kind of disclosure that we've been talking so much about, because we don't think that this is a consumer information piece at this point. It is something we feel very committed to doing to trying to do something about the maldistribution of risk.

I would really commend the health plans in the HIPC to be willing to do this. This is really pioneering work, and I'm sure the experts around this table can immediately see the weaknesses of it. It is in-patient based. That is a weakness. We would like to move to including high-cost pharmacy information.

The protease inhibitors that have come into the environment in the last few years. If a health plan is a prescribing a lot of those, they're probably being adversely selected on risk. But today there isn't the health plan infrastructure to track that.

I included in the last two pages of the handout for those of you that would really like to learn a lot about this, we have a 140-page book, which if anyone would like to give me their business card, it goes through all the math of all the calculations.

So what this chart shows you, and I'll tell you the three most important columns. First most important column is column B. That is the scores for all the plans in the HIPC. It shows how we think risk is distributed. And that is when we decide whether or not we're going to move money around.

And then column Q hows how much we're actually moving, and just to help you read that, if you go to top of column Q, Blue Shield point of service plan is receiving $2.11 cents member per months. And where is the money coming from? It's coming from the plans in column Q that have parentheses around their dollar values.

So it's coming from the Cal Advantage PPO. It would be coming from Care America, and then Metro Health. And all this information is provided to the health plans before we negotiate the price with them so they can see what the impact on premium is going to be. That was a very high glossy overview of the process.

Dr. Enthoven, is that what you were looking for?

CHAIRMAN ENTHOVEN: Absolutely. Thank you very much. That's very good. And you're very much to be commended I think for your courage and ingenuity in taking this important idea into a practice.

Before we go on to Dr. Bergthold, what I'd like to ask the two of you is in practical terms, now, looking out across the state of California, how do we -- what steps could we take to get this thing -- who should be hearing it? Is it PBGH, CalPERS? I know CalPERS is thinking seriously about it. Medi-Cal.

Clark Kerr made a suggestion in his group that the Medi-Cal program seek an arrangement with the Health Care Financing Administration to start doing a fair, purchasing groups. What should the task force

recommend beyond just saying this is a really important thing to do? Have you had thoughts about that?

Linda, if you have thoughts, also, please feel free to -- I'd like you just to focus us on that.

DR. BERGTHOLD: We're only going to get better at doing this by doing it.

CHAIRMAN ENTHOVEN: Right.

DR. BERGTHOLD: HIPC tried it, and we are totally committed to the process. But the HIPC is a 134,000 people in a great big 30 million people seat. And in order for us to move the technology, if you will, to art, we need other large purchasers to come on board.

Now, over time, we will standardize what we all mean by risk maldistribution, and we will all use the same measures, and the federal government is going to nudge us because they're very interested in this for Medicare.

But I am always trying to meet with powers and Margaret Stanley to encourage them. We need some other big organized purchasers to embrace this because health plans are very willing to help us figure out how to improve it. And we need their help. We need their brightest people on this because there is a lot of art to it.

Our very simple, albeit simple method, takes a 140 pages of math detail to explain. And I don't say that to be off-putting. It's math that any one of us can work through, it's just a lot of calculations.

And so I'd say, yes, organized purchasers need to start this. One of the big challenges is how are we going to do it when we go across benefit designs? HIPC has a standard benefit design. One of the key advisors on the project was John Bertco. He was a consulting actuary we worked with.

He very much believes we don't need standard benefit designs to risk adjust across the market. But I think we would learn more if we could get another big purchaser to have the standard benefit design to develop a method that they think works, and then maybe think about taking it across benefit packages that are not the same.

MR. LUFT: I think it's variance that we really need more of. Variance in multiple settings. Sandra pointed out how they had decided not to risk adjust down to zero but to have this corridor. That may or may not be the right long-term decision. It certainly makes it a lot easier because you don't have lots of money moving around back and forth to all net out at some point.

Health plans, when I've talked with some of them, they say, "Well, this is awfully risky. We know our business now. And I don't know how it would work out in this future." Well, I said, it's got to reduce your risk. But I know what my budget was last year. I can project it next year. This is uncertainty, not risk. Developing from experience with working in these different settings, I would say probably added on PBGH, CalPERS.

On the MediCal side, there's work done with

the state of Colorado and other states on the Medicare table, very extensive, of people within Medicaid. There will probably be proposals coming out of HCFA for Medicare. California is what? 35 percent of all the Medicare beneficiaries in managed care? That's going to start happening, and we need to figure out how to make that work through.

Some of the health plans that are not getting data from their medical groups -- I've got to believe that medical groups have the data. Otherwise, they're not doing anything. I think they have the data. They may not be willing to share it to a health plan that's only paying them a flat capitation fee. But if there's risk-adjusted payments coming from health plans based upon the ability to provide data, I suspect the data will appear.

Now, the negotiation between the health plan and the medical group might be an interesting discussion. That needs to worked out between plans.

DR. SHEWRY: That's an excellent point. The plans that I've indicated to you were low-risk in the HIPC. They may be low risk, or they may be that they don't have the data to support the process, or they didn't bother look at the data. Because in this process, you're rewarded for identifying people with high cost diagnoses, so you can become a payer either based on what we want to be looking at, the real distribution of numbers, or you can become a payer because you don't have the

infrastructure. Hal's absolutely right. They will build it if we do this.

MR. LUFT: I think Sandra's earlier point, the HIPC is large, but it's not big enough for any one of those health plans to develop a data system or to go through the negotiations. They'd rather walk away from that business, the 1,000, 2,000 enrollees than to deal with that issue. I don't think any of the plans dealing with CalPERS or PBGH will walk away from that business.

CHAIRMAN ENTHOVEN: Let's us say that a possible step would be should the task force recommend to the legislature that the legislature require CalPERS to go into risk adjustment? As I say those words, I kind of cringe because CalPERS is doing such a good job and we're filtering this through --

MR. LEE: Do you have any reason to believe that CalPERS would not want to do it?

CHAIRMAN ENTHOVEN: No. I think that -- I haven't talked with Margaret Stanley for a while now, but my impression has been that she took the lead up in the state of Washington, and she's fully totally understanding of the need for it, and so -- on the other hand, they haven't done it for whatever reason exactly, I don't know, except maybe they had to wait for Sandra to show the way.

Yes.

UNIDENTIFIED SPEAKER: I'm sitting in for David Tirapelli. I work for the Department of Personnel Administration. I'm a health benefit advisor for the

Department. I work closely with PERS. And I've been on their constituent task force. And we just recently worked on an RFP to go out for a bid for different types of health delivery service, point of service, EPA's, that type of thing, and also for risk adjusted -- information on risk adjusting with premiums. The problem I have with that is only going to be adjusted for age to begin with.

We are the employer, and so it looks to us like premiums of all the low cost plans will go up to subsidize the PERS care plan. So we have a philosophical disagreement with PERS on their approach to risk adjustment.

But I really like what Sandra has covered here today. I think that's a fairer approach. And I've already made myself a note to share that when I get back.

CHAIRMAN ENTHOVEN: You run into the damndest paradoxes in this whole thing. Last time I was talking with Margaret about it, which was some time ago, about the following problem, which is the state has a maximum contribution level, and all the HMO's are below that, and the PPO's are above that.

And so if you do risk adjustment, what you're going to do is raise the effective premium of the HMO's. This is assuming, I think we all believe, which is the PPO's are adversely selected. That was your experience.

So when you go through this, then you raise the premiums of the HMO's, which will be paid for by the

state, you lower the premiums of PPO's, which are paid for by the employees. And the net is that it costs the state money, unless we can get -- you know, unless EPA can get a new contract which goes for defining contributions. In other words, we have to have a genuine defining contribution system to make this thing make sense. That was the last hang up.

MR. LUFT: I think you put your finger on it. To some extent it's a political question. It's not a technical question. We've sort of made the transition from a defined benefit to a defined contribution, but we've not really made that in a public way. And I think any kind of a risk adjustment approach, it's going to have to address that issue.

And I can see arguments on both sides. You can have a defined contribution and attach it to various external straits. Or, you can say, "Gee, there's a fixed dollar amount that's going to be available for salaries, wages, and benefits. And how you split it up is an issue to be addressed." But these aren't technical questions. They're not managed care questions. It's a compensation issue.

CHAIRMAN ENTHOVEN: So, like, we ought to recommend the legislature regarding PERS that they -- and I realize it's a collective bargaining issue here. If they go to defined contributions, which the state owes, and be willing to accept whatever small cost in the transition in the interest of making the system working

better and longer.

Does that make sense?

MR. LUFT: I don't know the political issues on this, but it strikes me that the important part is moving towards a risk adjusted payment to the plans, and how that gets played out with respect to defined contribution versus defined benefit. I don't think it's really your issue.

In other words, I think if you put that on the table, then it becomes a lightening rod, and the risk adjustment will get burned. The people on both sides of that issue will see where it is, and they will address it one way or another, but I wouldn't plan on recommending defined contribution versus defined benefit. I'd say risk adjustment is important to deal with the medical care system.

CHAIRMAN ENTHOVEN: Okay. But then if they say that's all very well, but that's going to cost us money that we don't have.

Do we need to just acknowledge that and say, "Yeah, we know that, but it's worth it anyway"?

MR. LUFT: We can make an argument that you need to put more money on the table sometimes. We've certainly seen that in other public policy. Where to make a transition happen, you sometimes need to put some money on the table to reach a better long-term solution.

CHAIRMAN ENTHOVEN: Right.

MR. SPURLOCK: I have a quick question. I'm

a big fan of risk adjustment. I think it's a wonderful thing. In fact, I have question in the back of my mind about a current environment where we have health plans emerging and then mega health plans, 5 million, 6 million members.

And I'm just wondering the value of risk assessment when you have such huge health plans. Would another alternative be to carve out the known high utilizers, the HIV patients and Gaucher's patients, and put them in a separate pool, and leave the rest of them without risk adjustment. Or would you get much out it of it? I'm just interested in your thoughts on the trade-off when you have such large numbers in health plans, and the need to risk adjust against large numbers versus carving out those high utilizers that we can identify ahead of time.

MR. LUFT: I think there may be good argument for delivery systems to identify subsystems this may want to specialize in the care of certain kinds of patients. I worry about carving out people, partly because people often have other family members that didn't need to be carved out. And that you sometimes want a -- instead of health care providers to take care of a family, i don't like the segmentation, the arbitrary segmentation of putting people into separate pools.

Now, the risk adjustment approach, if you look at what the HIPC did, I think it's a very good model, risk adjustment by family size and gender, they've already

included age and region bias, and they also have this outlier adjustment for high cost conditions.

I would deal with the high cost conditions a little differently, because if you're at state wide plans, you know, a much larger pool, you can actually follow and track the quality of care of the patient of capturing the same sort of thing.

And this goes back to, I think, Alain's earlier point at the beginning of the session. Right now a number of the health plans have entirely overlapping provider groups or close to overlapping provider groups. I'm not sure that's going to be a stable situation. And if you go into separate provider groups, then the question of these carve-outs becomes much more problematic.

If you deal with a notion of risk adjustment that's had a successful level and say, "We will pay whoever we're going to pay on a risk-adjusted basis," and they may stay with the health plan, they may filter down to the medical groups, it may be directed to medical groups or organizations that three years from now don't even exist today. You at least have the methodology in there rather than locking yourselves into a separate carve-out group.

The other problem with a carve-out group is they can have a monopoly. They would be the only provider for AIDS care or cystic fibrosis or whatever, and they set their price. And that's not a good thing either. They wouldn't have to be responsible for their patient.

MR. WERDEGAR: Following up real quick. The plans that are so large that everything averages out, all the risk adjustments have to occur within the plans at medical group level?

MR. LUFT: And the other thing, it's not clear that size means that everything averages out. Certainly, there are differences between plans like Kaiser that have been around for a long time that have third generation members and other plans that are relatively new that have attracted people from fee-for-service because it's a very easy transition.

I don't know which is larger, which has higher and which has lower risk. But size doesn't necessarily make things average out. I could get 6 million men and 6 million women, and they would still be at different sizes.

CHAIRMAN ENTHOVEN: And the incentive effect is the key point. We want to reward the development of excellence in caring for Gaucher's patients, et cetera.

MR. LEE: Couple observations, I think whatever the task force can do to nudge the biggest purchasers down the road is very important for communicative PERS. But I'm also worried about all the others. I don't want to leave all the folks that are covered outside of them the ones that don't have the option.

I think one of the observations you made that's very important for us to think about into the

overlaps of groups is the importance of data at the medical group level and do recommendations about standards around that collection, to be a building block for two years from now, three years from now, having risk adjustment that next year is in a PERS system, but four years from is in a small purchaser. So that's an observation.

Questions, one is what do you know about risk adjustment and risk adjustment capitation from the health plan level down to the medical group? Is that happening now?

And the second is I'm curious as to the percentage of the cost of administering this. You know, every time you hit a particular diagnosis, you do an audit, and you do a looking at that, how costly is the administration of this for the HIPC?

MR. LUFT: I know that there are some health plans that have some adjustments in paying their medical groups for AIDS patients and some other things, but I don't think there's a lot of it. I don't think there's a lot of high science in this part. And I think there ought to be more.

And I think part of the problem is that the plans are not getting paid on a risk adjustment basis. So, for example, if I were a health plan, and I had a medical group come to me and say, you know, "We have a lot of people with AIDS. We want an adjustment up in our capitation," no one ever comes in for an adjustment down.

And they say, "Well, what's the evidence of that? Everybody else is willing to do it for $60 per member per month. You don't want to contract with us? Okay." Which of course is the right answer from their perspective. They don't want that medical group with their patients.

So I think some of that needs to be played through. And the other piece, and this is a close, why don't you do your auditing and then I'll come back on that. I think there are two approaches to this.

DR. BERGTHOLD: Costs aren't too overwhelming. We do all the auditing on an annual basis. So we look at every report of a marker diagnoses for a prior year. Health plans probably need to spend a half a day with us. Most of them are done in a couple hours. They prepare all the documents, and then we send a team of two folks in to go through basically a hospital discharge report looking for coding, ICG9 codes that are on there.

The more expensive infrastructure you have to have is if you're going to ask health plans to put their premiums at risk, you're going to move money around, you have to keep that -- whatever you're using as the system -- very up to date and really reflect medical practice. So we probably spend $50,000 whenever we update what the marker diagnoses are. Which for a small operation like HIPC, that's a big deal. That's an administrative expense we have to absorb.

And what we're doing there is basically

asking health plans for complete files of all utilization for a one to two year period, and then muching and crunching all the different databases together. That's the expensive part. And the rest of the expense is really the work group.

And at this point, we funded that on really a voluntary basis. Said to our health plans, if you want to have a say of how it's designed, you know, send your best and your brightest. And they have.

CHAIRMAN ENTHOVEN: Of course, we can commence the economies of scale if we got PBGH, PERS, University of California, et cetera.

DR. BERGTHOLD: Let me just add one more thing that I think you might be able to do, Alain, as a task force, as a commission, and that is to recommend that any new legislation coming on line that creates new purchasing alliances be required to do certain things, perhaps have a standard benefit package, perhaps adopt a risk adjustment. I'm not prescribing -- I don't know how far you want to go in requiring versus suggesting, but there is a -- there are a number of pieces of legislation looming or lurking or whatever the word is you want to use out there that would open the marketplace for a lot more of these purchasing groups, and it's precisely these kinds of larger sponsor groups that really can move the marketplace.

MR. LUFT: Just to answer your question, for the conditions that we're looking at in our research

project, trying to build a database, in a sense the clinicians or the medical group would be able to have software that would allow them to have a pseudo electronic medical record for the relevant information for the care of patients in those high risk marker categories.

And that's not just a data collection thing that goes off into the great void and run some risk adjustment thing. But that would allow them to see on an on-time basis how their patient is doing relative to everybody in the database, which would be everybody in the country if you make this thing work by standard Medicare level.

That's probably five, six years down the road, but that's the model. So it actually becomes a cheaper way to handle things, not expensive. And you're focusing on the two to three percent of people who are accounting for a lot of money. And we really need to understand how to better take care of these people. The science and medicine in those areas is not really good.

MS. SHEWRY: Just to follow-up on Linda's point, the recently enacted healthy family's program, which is going to provide coverage for half a million low income children, the legislation authorizing that does include again permissive authority for the managed risk medical insurance board to go ahead and adopt a risk assessment, risk adjustment process. So we'll certainly be looking at that as we get the program developed.

CHAIRMAN ENTHOVEN: There's just tremendous

potential management advantages. We can really start thinking about practicing population based medicine in a much more effective way and kind of thinking of the epidemiology of cost and how to analyze what is bringing on that cost and where could we intervene. And I think like a lot of management information, as people learn to use it, it could just be tremendous saving.

Michael.

MR. KARPF: I think Dr. Luft has answered my questions. You've actually defined and standarized your markers so that there are no issues with coding or no manipulations through coding processes?

MR. LUFT: I can't promise no, but the point is --

MR. KARPF: We have a lot of creative people.

MR. LUFT: When we were getting into this, we were noticing that the ICD9 codes for HIV disease is 042. The ICD9 code for hypertension is 402. A little bit of dyslexia that adds $30,000 a year in payment I would worry about.

But when you get into a clinical database and you're saying, "What is the CD4 count and the viral load for this patient? What protease inhibitor are they on? All of a sudden either you are committing outright fraud on a major scale, or you say, "Gee, this patient doesn't belong in this category." And so that's why those categories would switch into a separate clinical database,

where it would become very apparent that they're real cases.

It also means that would could, with appropriate confidentiality issues and things of that sort, have questionnaires go out to the patients and say, "How are you functioning? How is your experience with the health care system? Do you understand your meds? What about your side effect?" Et cetera. So it's not necessarily dependent on only what gets entered. You have access there to the individual patient for the consumer feedback.

CHAIRMAN ENTHOVEN: Keith.

MR. BISHOP: Yeah. I had two questions. One is the fundamental objective you're trying to achieve in doing this process and then whether this is, in fact, the most cost effective way of achieving that objective and whether any alternatives have been considered to do that.

And secondly, it seems to me in my everyday life, there is a lot of experience with risk selection. We know that they don't like things like smokers, skydivers, automobile companies don't like people with a lot of tickets. That's obviously rational behavior on the part of the plans.

But it might be good in terms of public health, the behavioral selection might be good. Because at some point there's a difference between what is luck of the draw versus behavioral and what is a mixed behavior

and intrinsic, endogenous problem. At some point, you get more problems about how you --

MR. LUFT: I think there are different layers of risk adjustment. The very simplest one is age and gender. And you ought to do that. That's a no brainer. Those things don't vary, easy to collect, every health plan ought to know the age and gender of their enrollees. It's that simple.

Going into diagnoses provides more information. And when you think there are selection problems, you need to do it because age and gender aren't good enough. And if you worry about health plans being priced out of the market because they're doing the right thing and not avoiding high cost people, then you want to make that investment.

Going to the third level, the high cost marker conditions, I think it's worth doing, but I'm not sure of it. That's why that -- that's a research project, and we're designing this project to ask the tough questions, not the easy ones. Okay. So I'm saying this is an idea. Two and a half years from now, we ought to be able to give you the answer on that third level. But the first two I'm pretty clear about.

Now, there are some moral questions. I think on the life insurance issue, you could say, "Well, we know smokers are more likely to die early. Why should nonsmokers subsidize the smokers." On the health insurance side, not very many of those behaviors are

clearly linked.

There's a lot of cardiovascular disease. Even lung cancer isn't purely determined by smoking. There are a lot of people who get lung cancer who never smoke. It's not just behavioral.

Whether you want to not adjust for certain behavioral kinds of things, I would go back on the moral question, saying have we done as much as we can as a society to give as much education, as much information to counter the incentives that the tobacco industry or whoever is putting out there to have people do bad behaviors before making them or their family pay the extra financial cost of those things.

I see that as a minor issue that that's determining the medical problems we've been talking about no one in a clear way caused on their own. And I see it as a very different issue than what you might see on the life insurance side.

CHAIRMAN ENTHOVEN: Helen Rodriguez-Trias.

MS. RODRIGUEZ-TRIAS: Yeah. I had some concerns about the exclusions and the marker diagnoses and what that might mean in developing the system to gather more out-patient kind of information, mental illness and substance abuse.

MS. SHEWRY: I think you're looking at the exclusions I listed on slide seven. We excluded mental health and chemical dependency because the amount of benefit provided commonly in the small group market and in

the HIPC is limited to 20 -- 30 in-patient days, 20 out-patient visits, detoxification for chemical dependency, limited out-patient services.

When you are in a situation where services are limited, you get a lot of non-precision in diagnoses. You get people who need mental health services, getting them through other pieces of the benefit. And so we just didn't feel with the benefit structure we were working in that including those two made sense.

Trauma is not predictable. Car wrecks may happen at greater frequency at certain intersections, but we didn't really think that was really a health plan marketing or risk segmentation issue. And the health plans in our work groups thought excluding trauma made sense.

And then maternity, we felt we captured both through the age adjustment in the price and then the gender adjustment we made. Really the reason women under 50 are less expensive -- more expensive than men is the incidence of maternity and maternity costs. And so we thought we were capturing that through the gender factor. And we didn't want to double count it.

MR. ALPERT: You asked before, which I thought was a great question, whether or not the political slash economic issue, which the economics is what made it political, issues surrounding this should essentially preclude us from making a formal recommendation that this should be done as opposed to whether it's worth it.

And my position is that there's a very strong moral imperative to make a recommendation. Because the bottom line is you're saying, "Well, we appreciate you folks taking care of these real sick people and developed all of this and we're going to send you a Christmas card to thank you every year. I just don't think it's right. As a society, we should take that heat and make the recommendation.

Second of all, I think we should adopt what Peter Lee said. And that is make it a two-tier recommendation because the ultimate care here is providers and hospitals caring for people. All of this wonderful work that we've been presented with this morning, which I thought was fantastic, is based on the plans that are willing to take on those patients at higher risk, getting more money.

Now, there's another level to that. And what I would hate to see happen, and I think we should make our point clear, is that all the hospitals simply get what they're getting now, and everybody in lower management gets a nice Christmas bonus and a golden parachute. I would say let's make a recommendation and make it -- say we think it should go down to where the patient is being cared for.

CHAIRMAN ENTHOVEN: Right. On the moral point, not long before his death, Cardinal Bernadine, who was the leading spokesman for health care for the Catholic Church in his country gave an address called managing

managed care. And he had this great statement in there about the importance of risk adjustment saying if we don't do it then we're going to create powerful incentives that will lead us -- I'm not doing justice to the quote, but to the absurd situation in which the health care system is driven to avoid doing just what its purpose is, which is to take care of sick people.

MR. ALPERT: Absolutely. I think Dr. Luft's point about when we see the billboard that have pictures of people in wheelchairs and so forth and advertising those plans, we'll know that this equity has been reached.

Right now the billboards have gone astronomically in the opposite direction, and they say literally, "Join our plan. You don't have to be sick to be well." It's exactly the opposite direction. "We are the best at taking care of you if you've never been sick. You'll never be happier of being well if you buy our health insurance." We need it exactly the opposite direction.

CHAIRMAN ENTHOVEN: Now, we want to move to standardization.

MS. BERGTHOLD: I love taking about standardization when everyone is hungry. I can do this quickly to tell people things they don't know about standardization.

Let me pass around a couple of charts to make a couple of points that I'd like to make about this. Standardization of benefits, I appreciate Ron's comments

about using standards not standardization. It's a word Americans generally dislike, especially if it has to do with taking away their right to chose to ride a motorcycle without a helmet or whatever.

But when we talk about sponsor groups, actually we are doing a lot of standardization right now. And the first chart that I'm passing around will show you that about 95 percent of the large health -- large employers in this country already cover about the same services; that the variation in benefits that we already have is really quite actually small but significant.

I wanted to make two points. There is a lot going on. We have a standardized Medicare core benefit package. You have standardized supplemental plans now for Medicare. We have standardized packages for HMO's particularly for the HMO act we have pools like the HIPC that has standardized benefits. PBGH and CalPERS have a standardized benefits package and so forth. It's not something that is not happening in the system, no. 1.

The reason we do it mainly I think is for purposes of equity and simplicity. We lose something in the process when we go for that. But it is really important, I think, to understand one thing about helping consumers choose among plans, and that is they ought to have the same financial protection no matter what plan they chose.

And this morning there was a really good discussion about how little we all know around this table

even about what we choose when we choose a health plan.

We certainly should not be offering out to the community plans that basically don't treat diabetes to a diabetic or don't treat it to the same degree that another plan does. I think it's very important for consumers to be able to make sense, and I think one of the sort of mythical things that has happened in Sacramento in the last couple years was when Tom Elkins took the benefits packages for CalPERS and sort of laid them out in front of the board and said, you know, "If you can understand this, fine, but I can't. And we're going to try to put this on 8 1/2 by 14." And they did.

And what I based my comments on is a couple of experiences with doing this. One is with CalPERS, which I was with William Mercer at the time, and we were asked to come and do a second level benefits standardization for them after they had already done what they thought was a standardized benefit package, and then doing some work with other purchasing pools.

And lastly, most recently, working with the White House on an attempt to come up with core benefit package for all Americans that would be as the president chose, these were his words, "at least as good as what they already had." And when he discover what most people had, he was pretty shocked. It was quite comprehensive for the working population and so it would have listed the cost of a lot of other plans right up to that floor.

The reason for doing it was to try to make

it easier and simpler for consumers. Let me just mention a couple things about the problems or disadvantages of standardized benefit packages, because I think they are real. One is they can't -- a standardized package really can delay the introduction of new life-saving technologies if they require state or federal approval. And that is a difficulty for consumers as well as for providers.

It can also, as I mentioned, raise the cost for smaller self-insured firms that may not have been offering what the floor is now set at. And that's another issue to think about in terms of standardization.

It also -- and I think this is more rhetoric than reality, discourage innovation in benefit design. I think that is a total oxymoron. There isn't much innovation in benefit design. In fact, benefit design lags the delivery system in terms of its innovation by at least the decade as far as I can tell.

So the innovation issue -- I think innovation is sometimes the code word for risk selection. And I think we should sort of say maybe that's not the most important disadvantage.

But the new life-saving technologies and the raising of the cost is really an issue. And it also illuminates a market for supplemental insurance, which you then have to regulate as well. So it has its disadvantages.

Let me just mention a couple things about variation that you have in front of you. Although there

is a surprising amount of consistency in what's offered, there are eleven categories of covered services that almost everyone offers. There's a lot of state mandates about it, what you can offer. There are still major variations, and they fall into three pots. At least three pots, perhaps four, and I'd like you to think about that as you go on to discuss your recommendations.

The major variation come in probably less than 20 percent of the premium dollar. They come in mental health and substance abuse, rehab and extended care, prescription drugs, dental care, infertility services, abortion and investigational experimental treatments. Those variations fall, I think, in three categories. Categories where we really genuinely do not have good clinical agreement and consensus about what a standard treatment or approach or coverage should be. There's real clinical disagreement.

Secondly, there are good reasons for a health plan to want to risk -- to avoid the risk of covering those services. So that's another reason for variation. The third reason is there are genuine value differences in society about whether you or anyone should be paying for the service.

Namely, that comes from abortion, but infertility is I think a really interesting discussion. Should society pay you if you cannot bear children? How much should they pay you and how much should they continue to offer coverage to your employer, offer coverage to you?

Now, I would also make the point that consumers ought to be very much more involved in making decision about what's covered and what's not covered than they are. But particularly around the value differences. And I think that's really a legitimate input area for consumers to be able to discuss what is covered in that area.

It can get a little bit ridiculous in a way because you sort of get people saying as they did during the health reform, "I don't want a penny of my premium dollar going for anyone's abortion in my plan. Therefore, put that aside, make people pay for that in a completely separate way. My premium dollar will be contaminated by abortion or my premium dollar may be contaminated by blood transfusions or by organ transplants, with which I disagree or whatever."

So there is that issue to think about. The degree of variability in California is driven mainly by mandates. And you probably will be surprised to know that California has relatively few mandates compared to other studies. I'm sure most people in this room would not have thought that to be true.

But to the degree you have state mandates, you would have much more consistency of health benefits. And to the degree your mandates are fewer,the variations increase. So I guess what I would like to leave with this group is sort of some questions about the trade-offs between standardizing and then what, you know, can be done

and what employers like CalPERS have tried to do around these variations is to, first of all, let's say, you decided that standardization of benefit is an important thing to do. There should be a core benefit, and you want every health plan to compete on that basis. Not on the basis of whether they offer a certain service or not, but on quality and cost.

Once you've done that, you've only gone about 10 percent down the road. There will always be variation in benefit and service, and there should be. And there will be variation until we have clinical agreement about what is safe and effective treatment for certain conditions, which we of course don't have.

So some variation is okay. And it will always be with us. I think most of the employers like CalPERS have chosen to do deeper cuts in the variations as they emerged with experience. And what they asked us to do several years ago was to take a look at ten different coverages, and one of those coverages is in that chart that you have.

They thought they were providing standardized benefits for prevention. And as you can see from that chart, they were not providing. Their 18 health plans were not providing standardized coverage of those benefits. And they did not want Mrs. Jones who chose plan A to be getting a different kind of preventive benefit than Mrs. Smith who had chosen plan D or plan four. I can't remember how they're listed on that chart. But they

wanted their consumers to have equal access to those preventive benefits. So they gave it to us to take it to the clinicians to have a clinical panel look at why were those variations there.

They were there because of real clinical case disagreement. Elective abortions was one of the benefits they chose to have us take a look at. So there were value differences. Well, I think that you might want to recommend for sponsor groups that are providing health plans to populations, covered populations that will have choice.

In fact, let's just assume you do, like you're a member of HIPC. I think sponsor groups like that should have a process by which that design is developed with some consumer input, but that it always has a process by which on-going variation can be looked at and discussed, maybe not resolved. And that consumers ought to have input where there are value differences. And providers and clinic ought to be consulted about what is good practice or what is best practice. Because we know we have a lot of variation in medical practice that is just inattention or lack of knowledge of information.

CHAIRMAN ENTHOVEN: Let me just underly. What we're saying is different sponsor groups can have their own, but we're not saying everyone in California has got to have the same standard, but it's within the sponsor group.

MS. BERGTHOLD: So they have some way to

compare. Remember, benefit design variation is a tinkering activity, and the interesting thing to me, having been a part of that industry, which I think HAS actually driven costs up, but never mind that, has been the fact that benefit design tinkering has not been proven to be effective in pushing premiums down as collective has proved to be. And those large employers, PBGH, did not want to give up the right to give up tinkering. When they discovered tinkering wasn't saving them as much money.

CHAIRMAN ENTHOVEN: Or remuneristic California when they standardized. The market force of individual choice drove the prices down.

MR. KARPF: I'm having a little confusion in my own mind what you mean by standardized packages. Many of us think standardized packages, dollar amount of coverage, so much coverage for mental health care, prenatal, variety of different types of benefits. And then you start speaking to the issues of medicine based. Others of us think about what the Oregon experience has been like in terms of defining entities and approaches to entities in deciding which ones have enough -- which approaches have enough validity they should be covered. In your discussions, you seem to mix and match those two.

DR. BERGTHOLD: I cut that out for the sake of moving along. I think there are a couple of ways to standardize by category of services hospital in-patient lab radiology. You can standardize by cost shares.

I think actually both things are mostly

the way we approach standardization. You can standardize by how Oregon did it in terms of mixture in terms of treatment diagnosis. There are two articles in the New England Journal, update of the Oregon plan, and I think for those of you who follow that, I really admire what Oregon has tried to do, and find lack of political contention at this point over that plan has really attributed to a great degree to the fact that they involve their stakeholders.

Now, I wouldn't exactly say it's public, because only about five percent of the Medicaid population actually participated in the town halls, but most were educated stakeholders that participated in that process, and I think they've been able to do something unique with standardization and provider situation that we ought to be moving towards. But we don't really have the evidence yet to do a completely evidence based model approach. That's why we're not doing it more.

MR. KARPF: The other issue I'd like to comment on, this country has been committed to pushing the front tires of medicine and support. The standardize packaging doesn't create that problem. It makes that problem explicit for us.

DR. BERGTHOLD: In what way, in terms of standardization of medicine, whether it can be supported or not.

MR. HIELPLER: With regard to that subject, has there been any discussions that they concluded for

some reason or another to prove beneficial in allowing them to exclude that so there's information on the front end that this is something -- because in the work that we've seen, all of them know the top ten things that they are going to deny. But they never specify those things. There's an argument. Knox-Keene prohibits some of that. Some of these things will change over time.

Usually they tell you we don't see any. You have coverage coming out every six months. Any ideas whether that's advantageous from an informational standpoint to allow them to specifically exclude what they're paying for, what they're not for the most specifically denied procedures under that category?

DR. BERGTHOLD: I think what is covered does not need to be more explicit. It's so dam hard to understand it. It is really difficult to understand those benefit booklets. And I guess I would plead for the commission to make at the very least some strong statement about the need to make this information more understandable. And to make -- one of the things that I'm very involved in is trying to understand whether we -- what we mean when we say something will be covered if it's medically necessary. And whether that term even means anything anymore or should be thrown out and replaced with something more useful.

I think it's very important to begin to give that information to people and to begin to give people the kinds of information about the variations between plans so

that, I mean, the risk selection issue really becomes very clear there. But, I mean, if you are a person who thinks you're going to need a blood product, you would be quite surprised to know how differently the major plans in California deal with covering blood products.

CHAIRMAN ENTHOVEN: Great thing was standardization. We found CalPERS. They kind of bring it under management control instead of each man doing things different in the fine print. At least you can get it out, open it, examine it, look at it. For our group, we want these blood products covered. In a famous Tom Elkin episode, one of the plans in the old print covered organ transplants. In the fine print it excluded coverage of the harvesting and transporting of the organ.

MR. LUFT: Just on that point, and obviously you've all been discussing this in much more depth, it strikes me that there are two issues here. One, I think health plans ought to be able to explore various changes in benefits packages. They may decide that the guidelines on preventive visits aren't the right ones and they want to make changes.

They ought to be able to do that with full disclosure. And in some sense, perhaps with some real evidence that they're going to be testing; that it's not just an arbitrary change. We've changed for half of our population. We're going to follow them, et cetera, and we're doing this.

In terms of the information, presentation,

we might -- you might start thinking about how the web could be used. You could have available -- I mean part of the problem is you don't have health plans sending out information to all their beneficiaries every time they make a change.

They can post it on the web site, and it would be managed by some neutral source, so you could look across, here's what that covers. Here's what they don't. So that could be a way to deal with the information problem much more effectively, and it would be real clear.

CHAIRMAN ENTHOVEN: Thank you very much. I really appreciate that.

MR. WERDEGAR: Just to link to the two discussions, in order to do risk adjustment, a purchasing cooperative or purchasing pool should have standardized benefits packages across all their plans. It makes it a little easier, or how essential is that?

MS. BERGTHOLD: It's one way it makes it easier, but the key problem is, if you've got health plans, let's say you have one health plan that doesn't cover blood products, how do you in the risk adjustment take the fact that some of these people are getting blood products paid for in some health plans and not in others? And then they're saying, "Well, we don't believe in it." And then it gets to the moral issues Linda raised. It certainly becomes easier if you have a relatively standard product.

CHAIRMAN ENTHOVEN: Okay. Thank you very

much.

(Whereupon a luncheon recess was taken.)

CHAIRMAN ENTHOVEN: I'd like to call the task force back to order. We're going to do a few things briefly, but a little bit out of order. First of all, we have a member of the general public, Mr. Thomas Swan, who is an AIDS activist who wants to address us briefly about AIDS discrimination.

Is Mr. Swan here? We're taking him out of order because I understand that his health situation makes it very difficult for him. But is he here? Mr. Swan?

Okay. Mr. Swan, let me just say, I do -- I'm very sympathetic with your health situation, and I do regret that you were not here for this morning's discussion, which was on the very important subject of risk adjustment, which is kind of an economic engine that describes -- that drives the incentives with respect to care for AIDS patients and patients with other very costly chronic conditions, and the point that our panel has made that I think is widely supported by the members of the task force is that we must convert our financing model to a system that is called risk adjustment so that health plans who care for, for example, AIDS patients and are -- make themselves attractive to AIDS patients through their expertise in that field are rewarded financially rather upon than penalized financially.

So I think everybody here understands, and I

say that on the basis of previous conversations we've had, about the existing of financing system that pays the same amount of money per capita for the totally healthy young person and for the AIDS patients. It has built into it what has frequently been described as a perverse incentive. It needs to be corrected so that the payment system reflects the medical needs of the person.

So that, I just want to tell you, is quite clearly understood, and I'd be very surprised if we didn't have near unanimity on the need to convert to the new risk adjustment system.

So I hope you won't feel it's necessary to review all that because I think that is understood, and we're happy to have you with us, and we want to hear what you have to say. We hope that you can make it fairly concise.

MR. SWAN: Mr. Chairman, I appreciate your remarks, and I wasn't going to touch on that in my verbal comments today, but that is one of the topics included in my written testimony. Again, my name is Thomas A. Swan, and I live in Port Hueneme, which is Ventura County.

I have lived with AIDS since 1990, and I feel the task force must hear from someone with this illness. Every morning I wake up, open my eyes and say, oh, God, I'm still blind.

In October, 1995, I began to experience some blurring of my vision in my left eye. I was at risk for developing cytomegalovirus or CMV, which is the most

prevalent, viral, opportunistic pathogen in HIV positive patients.

My Blue Cross California Care primary care physician referred me to an ophthalmologist on the HMO plan. The ophthalmologist delayed my scheduled examination for two months. When I arrived for my appointment in December, the ophthalmologist refused to shake my hand when we met. He made me feel even less welcome by asking three times why are you here.

The ophthalmologist had me read an eye chart and noted poor vision in my left eye, but he failed to examine my retina. When I asked for a retinal examination, visual field test, and follow-up appointments, the ophthalmologist declined, telling me, "I have asked your doctor to stop sending me AIDS patients. Don't come back until you really can't see."

In March of 1996, four months later, I went to my doctor's office and covered my right eye with my hand. I demonstrated with my doctor with my left eye I could not see his face or shirt, but I could see his pants and shoes. My doctor told me CMV has reduced your field of vision. I asked if I could go to the emergency room, and my doctor said no. Instead my doctor told me to drive home.

I sat in my condominium all alone for nine days slowly going blind. I would see a white flash and my eye would hurt. Each day I could see less and less. Finally, after nine days, the ophthalmologist agreed to

see me again. After a brief exam, he said, "I knew this would happen."

I failed the visual field test and Blue Cross California Care still would not prescribe treatment for my diagnosed life-threatening condition. My family and friends thought I was going to die.

I wanted to live so I asked a volunteer to drive me to the U.C.L.A. institute. There I was enrolled in a federally-funded AIDS medical research project and given free infusions. The taxpayers provided me with retinal examinations and medicine for over seven months. This was medical care denied by the managed health care system.

Therefore, I'd like to call upon this task force to include a statement in your final report that HMOs should not tolerate discrimination against AIDS patients.

And in my written testimony, I go further and recommend that perhaps training is necessary, and that we take steps to form advisory panels with the -- with the AIDS patients in this state with various HMOs. And my second recommendation is that you include in your final report that HMOs refer AIDS patients to specialists.

Let me make this perfectly clear, the vision, the hearing, the eyes, the ears, everything about AIDS patients is worth saving. We should be fighting AIDS, not people.

I'm speaking out so no other person living

with AIDS gets the runaround and goes blind like I did. There is a tragedy that should not have happened. It's very depressing to be blind. I could stay home, but I came here today to try and improve the managed health care system.

In conclusion, let me say this: I'll never give up hope or give in to discrimination. I'll never give up hope and give in to AIDS.

Do you have any questions?

CHAIRMAN ENTHOVEN: Peter.

MR. LEE: I don't have a question so much as a comment. One of the things that you may not know that we got handed this morning is background material and recommendations developed by the San Francisco AIDS Foundation along with the project INFORM.

I've had a chance to look at this, and I really commend the task force members who spent time looking through both the background material and recommendations which echo a number of yours.

And I know we get swamped with papers, but one of the real challenges for managed care is caring for people who are quote, unquote, expensive. That is the job of the health care system, and that is in providing care for those who need it most, and I think people with AIDS and HIV in some ways can serve as the canaries in the tunnel, so to speak. And the experience that you shared with us is very important, and I recommend the rest of us consider your testimony and what we got today.

CHAIRMAN ENTHOVEN: Mark.

MR. HEILPLER: Mr. Swan, you made reference to the fact that your doctor, primary care, informed you he was paid $9 a month. Did you have any knowledge as to that's how the system worked when you signed up?

MR. SWAN: I've been a licensed insurance agent in this state since 1984. I used to sell Blue Cross insurance until I went on AIDS disability. So I did have an understanding of that. And I've been in AIDS medical research since 1985 before I became infected with HIV. I was still trying to help our country find a cure.

And the thing is my primary care physician basically told me he was overworked and underpaid, and that there was no incentive for him to refer me to a specialist, and he didn't have the time to study up on the new AIDS medical treatments.

And what I have found is that Ventura County Medical Center, indigent patients can go once a month and get a free retinal examination and a screening for CMV. And I tried for four months to get a retinal exam and was turned down by my private medical insurance.

It's very frustrating for me because when I was 18 years old I joined the Marine Corps. I served our country during the Iranian hostage crisis. I'm very proud of that. I love this country. And I have private medical insurance because I've worked my entire adult life until I became disabled with AIDS.

I don't want to put people down that are

indigent, but the facts are that if you have AIDS in this state, you get better health care from the government. When I had to go to U.C.L.A. to get the medicine that Blue Cross denied me, I think that's wrong.

I think we need to improve the system and make sure that these new AIDS treatments are available. It is expensive, and the doctors do have to stay on top of these breakthroughs. The face of AIDS is changing rapidly, almost every week. You can read the Los Angeles Times of a drug combination, a new treatment program, and you have to stay on top of it.

And so we need to refer AIDS patients to specialists, and we need to make sure that there is some compensation so they can keep on top of the treatments and make sure that it gets to the patients. And I've said this over and over and over again.

Right now my HIV level is undetectable. The doctors say I'm going to live for years to come. I have no opportunistic infections, and right now the money that's being paid for the medicine is keeping me out of the hospital.

So I -- when I met with the regional director of Blue Cross, May the 15th in Woodland Hills, I told him, "If you had referred me to an AIDS specialist sooner, you would have saved money in the long run." Because the doctor that's helping me now is better trained, can better diagnose my condition, knows what treatments to prescribe. I'm healthier, and if it wasn't

for this blindness, I would be working today.

CHAIRMAN ENTHOVEN: Thank you. Any other questions? Thank you very much, Mr. Swan.

Next I'd like to call on Keith Bishop. While I was high in the mountains, apparently Keith decided that he was going to resign. I heard that when I got back, and I was very sorry to hear that.

I've enjoyed working with you and gained a great deal of respect for your ability and dedication. But I'd like to call on you for anything you'd like to say to the task force.

MR. BISHOP: Thank you, Alain. I would like -- last week I gave a speech on Wednesday, and that was the day the press reported the story that I was resigning. And the gentleman who was introducing me came up with a good line. He said well, I've been a lame duck. So he told everyone that you're going to get a swan song from a lame duck. So today is my swan song.

I'm going to be out of the office a week from today, and I've got a very busy schedule between now and then, and I'm looking forward to going back to the private sector.

I know there's probably been some speculation about why I left. The reasons are really truly personal. I have very much enjoyed the position of commissioner and would have liked to have stayed on, but family commitments called me elsewhere, and so that's what I'm going to do.

I've also enjoyed the opportunity of working with everyone on this task force and getting to know some of you.

I think the work of the task force has been very important. California has led the country in the move towards managed care, and it's appropriate, I think, for this state and the people of the state to take a minute to reflect on where we've been and where we're going, and I think in that sense that this task force is very important.

There are a couple of thoughts, if you will bear with me for a minute, I'd like to leave you with. I would encourage this task force to act on the basis of facts. As I've been in the office of commissioner, the carpet is worn down at my doorstep with people who want me to do something about something.

And usually, you know, the facts are very incomplete. And I've always tried to investigate matters fully before taking action. There's a lot of rhetoric out there. There's a lot of strong feelings. But it's important to be anchored to the facts.

I'd also encourage the task force to remember that we are a country of laws. Many of the things we've been asked to do, it seems to me, have, you know, gone beyond our system of laws. And I'll give you an example.

In the midst of the pending HMO merger, one legislator asked me to defer a decision on those mergers.

I thought that was wrong. We had a set of rules. They were on the books.

And, of course, it's the legislator's prerogative to change those rulings, but until they are changed, I think it's my obligation to follow the laws; that we should regulate based on the laws and not based on with him.

And, finally, I guess there's been a lot of talk about consumers on this task force. I believe very much in empowering consumers. Frankly, I don't think consumers will be empowered unless we treat them with respect and dignity and leave them with the authority to make their own autonomous decisions. And the best way to do that is to level the playing field between purchasers supplying health coverage and individual purchased health coverage.

I think until people are put back in control of their premium dollars, it's very difficult. You can provide them with information. You can provide them with a lot of things, but unless they can control how their health dollars are being spent, they're going to be made dependent either upon their employer or the government. And I don't think that is particularly empowering.

I want to thank everyone for their work. I want to assure you that the Department of Corporations is in good hands. Gary Hagan is going to continue as the head of the health plan division, and I'm sure that the department will move forward in my absence.

We've got a lot of things underway, including the implementation of the six and a half million dollar budget augmentation for the health plan division, and a three and a half million dollar augmentation for a document imaging system. And those are all well underway, and I expect them to continue. Thank you very much.

CHAIRMAN ENTHOVEN: Thank you. Anyone want to comment on that?

MR. GALLEGOS: As chairman of the assembly health committee and pretty well known to be a leading reform advocate for managed care, Mr. Bishop and I have had a number of occasions to have to work together and, in many cases, be on opposite ends of issues.

But I just want to say that this past year as chair, I've had the good fortune of having Mr. Bishop as the commissioner to work with, as well as Gary Hagan, whom I know is out in the audience, and I can say from personal experience that Mr. Bishop has always been a gentleman. He's always been respectful and courteous, even though we have, as I said, many times been at opposite ends of issues. And I certainly regret that you'll be leaving.

Personally, I want to wish you the very best, and I'm sure it's a decision that was difficult for you, and that you made what you felt was your interest.

And I commend you for the work and being willing to get involved in a very hot, sometimes controversial issue in the state of California, and it's

not an issue with easy solutions, and you've handled yourself tremendous -- as a tremendous professional and with dignity, and I think that you did the Department of Corporations a great deal of justice by serving the time that you did. And I wish you the best, and I thank you for the opportunity to work with you on some of these very critical issues here in the state of California.

MR. BISHOP: Thank you.

CHAIRMAN ENTHOVEN: Thank you, Martin. Thank you very much, Keith. We appreciate the job you've done.

Without objection, I'd like to change -- I need to change the order so that the next subject on our calendar will be perspectives on managed care, California Academy Medicine.

We have a panel of several presenters: William H. Gurtner, Vice President, Clinical Services Development, University of California.

Brian Bull, Vice President, Clinical Faculty, Dean of Loma Linda University School of Medicine.

Jeffrey Huffman, President, CEO, USC's Care Medical Group. Kenneth Wolfe, PhD, Assistant Dean for Educational Affairs, Edgar University School of Medicine.

And Joseph Hopkins, Stanford Health Services and Medical Director for Health Plans.

We request that each speaker present for approximately ten minutes. And then once the presentation has finished, we'll have general discussion.

As the task force members know, we have an expert resource group working on Academy Medical Centers, which will present its findings to the task force October 10th. And I remind everyone also, part of our legislative mandate is a report to the legislature on the impact of managed care on medical academia.

I would appreciate it if you could make a special effort to confine each of your sets of remark to the ten minutes so that there will be time for interaction and discussion.

Can we go in the order that I read? Is that satisfactory? Let's start with Mr. Werdegar.

MR. GURTNER: Thank you, Mr. Chairman.

First of all, I would like to thank the committee for the opportunity to talk with you a few minutes. I will keep my comments brief. I have a set of papers that I will pass out afterwards so that you have some documentation of the discussion.

I know you've had much debate about the role of managed care as it affects care delivered in California in general. And certainly, you will be talking more about the impacts on the medical centers. I for one am here today to speak a little bit more on perhaps a slightly different view.

I think the most critical issue, I believe, coming out of this committee will be the fact that we will have a basis for the debate coming in the legislature as to the future of managed care, and that you in many ways

will frame that debate.

In framing that debate, I think one of the issues that have been lost began to reemerge this year relative to county options and managed Medi-Cal, et cetera, was really the question of resource management, and the issue of looking at the academic medical centers as an asset within the state of California.

And I think what makes me concerned -- and I'm somebody who spends a lot of time in the private sector as well as the academic sector now -- is that we tend to create public policy and change. Certainly, I think managed care is a good example of that, somewhat in isolation of the other systems.

And I think in reality that the impetus is the need to modify the way health care was delivered in California. And all of the good things that managed care has brought to that marketplace in its early discussions and debates, I don't believe took into account the impacts, the domino effect, that managed care would have as it relates to a -- perhaps a different set of, if not a broader set of assets owned and operated by the State of California.

And speaking specifically of the University of California, I think that we have to recognize that the implications of shifting the managed care -- shifting care into a managed care marketplace from a historical system has had dramatic effects on that system. So let me take a few moments with some slides.

I think you can hear me. I'll step away from the microphone and make this relatively brief. If we can turn this on.

Very briefly, as many of you know, if you think about the University of California, something other than just an academic school, but think about it as an asset of the state, when you begin to recognize that it has some size and impact on the state that you might not otherwise expect.

For instance, you have 12,000 students enrolled in health science education at any given time. You have approximately 116,500 discharges from that system and annual outpatient visits at 2.7 million. And indeed we know that several institutions within the system are primary participants in care of the indigent throughout the state.

It's also true that there are many benefits generated by both managed care and academic medical centers. And I think we need to recognize at the current level, the University of California Medical Center system is not only dependent on it, but certainly deeply involved in the managed care marketplace.

We have 50 percent of the population enrolled, and at the present time, you have 33 percent inpatient stays, and 39 percent of revenues come from managed care products and the patients that are involved.

It's had its impacts on the system, and I'm not here speaking or would suggest to you that the

direction managed care has driven the cost structure in California is inappropriate. I leave that to other discussion.

What I'm trying to point out, there has been dramatic impact, and we need to understand what that impact is risking or, in fact, automatically changing. We are responding to these changes.

In hindsight, the question is, will we be all pleased with the end result? And I want to make the point that you're talking about dramatic shifts in revenue in short periods of time, and all of you involved in this business one way or another understand, and I think empathize with the -- with the impact that that sort of change has.

Again, you've seen, as this says, significant change. The other point to be made in this discussion is that one of the products of the University of California of the system is research. It is the secondary product certainly to the manage care system and to the patient care. But it is, in fact, one of the benefits of the system to the State and needs to be recognized as a by-product of that system.

And the real question that I think that I want to stress -- and I'll come back to this again at the end -- is that is, in fact, the changes we are directing in managed care, have we, in fact, sacrificed a significant piece of the State resource built into this academic system that may or may not be the same or survive

as well.

In my view, there are several problems involved here. We have -- we have -- we are entering into a period of time of uncharted waters, as we say, in terms of the future of the academic system because of the consequences of the managed care shifts in revenue streams. It is having a clear impact on research.

The other thing we know better than anybody else, and it's one that I hope you would spend some time on, is none of us know enough about the system. We do not have good information. We need to spend a lot of time on that on both sides of the equation so we can clearly begin to recognize the implications.

I do believe that both managed care as a process and as an impact on the system has had many positive results. I also believe that the University, by definition, has those impacts.

So indeed there is a value and perhaps a directly quantifiable value of that impact on the public health and well-being, the state of the art medical education, and the technology that results from that system.

Those economic benefits, some are obvious, and some aren't so. When you look at us as a producer of revenue streams in the state of California, in terms of the start-up industries that are generated, in terms of the academic climate that tends to be set up around these university settings.

The best example, if you look at what's happening in Irvine and the development of the new clean industry technology developing around that university, and it's happening -- it happens at almost every university setting.

There's also the issue of certainly the community participation. 15,500 employed, not that it seems that large, in parks in the state of California. Payroll in excess of a million dollars. Medical center capital expenditures of $232 billion annually.

Another point I wanted to make sure you understand in your discussions and debates is that if you look at the academic medical centers, not medical schools, academic medical centers, people assume there's a state support of this. Not true. Five percent is the support. If you add the medical schools to that, you approach 12 percent, but this has been historically a self-sustaining system.

I just picked a few random pieces throughout the system to give you a flavor of some of the implications and what's happening. You talk about the contributions to uncompensated care, the goods and services, the national rankings in terms of primary care.

I think we forget that part of this whole change requires a significant change in manpower and the restructuring and the way that's delivered. Well, unless we're at the table in that debate, this change isn't going to happen the way you want it to happen.

You can't deal with managed care and isolation. Managed care, in my view, is a process on top of the system. How the system reacts to that process is the key challenge.

Just a couple of other facts. Michael will understand the first quote. I want to make sure that we have that one up there. We are the largest employers. Private federal contracts is the big issue.

The last item can be generated at every campus. This one is here because we just did a quick study to find out indeed what the generation is out of the san Diego campus. 39 new technology industries have been developed directly out of research at that campus. Now, you multiply that times five and you're looking at a State asset of significance.

We can talk a lot about mechanics how managed care and the revenue stream should be dealt with at the University and in this academic system. My message to you is that if we only view this as a critical payment treatment, and that the assumption from that is level playing field in the sense of we should all be market responsible, and don't at the same time at least step back and begin to think from a public policy point of view of the implications for the state resources in those decisions, then we will make some tragic mistakes.

I am not suggesting that the academic medical center is entitled to this incredible difference. I don't think we know what that -- what that value is or

what it means to put those at risk or to, in fact, support them. I think we need to study that and come to some public agreed upon analysis of that.

What I am saying to you is in your deliberations, thinking through how the private sector, the insurance industry, and the private providers of care, be they children's hospitals, university hospitals or whatever, there is an asset here to the State that we should not have. Please put that in your analysis and give it serious thought as you proceed.

CHAIRMAN ENTHOVEN: Thank you, Mr. Gurtner.

Next, Dr. Brian Bull, Vice President of Clinical Faculty and Dean of Loma Linda University School of Medicine.

DR. GOLD: Thank you for the privilege of addressing you this afternoon. I'd like to begin my remarks by quoting from two of the morning's speakers.

Dr. Enthoven, and I quote, "We want to reward the development of excellence in caring for sick patients." Dr. Luft, "I wouldn't want to make my client attractive to women at risk of breast cancer, for if I followed their advice," their being consumer groups, "and made myself attractive, I'd go bankrupt."

I think those two quotes delineate the problem that all quality providers of health care in California find themselves in, particularly academic medical centers.

The preceding speaker has done me a favor by

covering the first half of my notes so I'll begin in the middle. I'd like you to turn in the handout to Page 4. It begins, "Assumptions underlying capitated health care." And I wanted to address my remarks to the question of adverse selection.

Adverse selection is real. And adverse selection affects not only academic medical centers but all providers who are perceived to be of higher quality in the health care market. There are providers that are perceived to be of higher quality. The Journal of the American Medical Association recognizes that.

On the next page of the handout, I quote, Non-white physicians more likely to care for minority, medically indigent, and sicker patients. Caring for less affluent and sicker patients may financially penalize non-white physicians and make them particularly vulnerable to capitation arrangements.

The assumption underlying capitated health care in a nonrisk-adjusted environment, which is the environment in which we find ourselves today, makes the assumption that all providers in the health care system are considered to be equivalent as the payment is equivalent. But as I mentioned, each JAMA recognizes that each individual patients may be perceived as better able to care for certain classes of patients.

In this case, its indigent patients and non-white patients in the inner city. There are many ways in which a physician can achieve a reputation for quality.

One of those was demonstrated in one of the previous slides.

There is a listing of the best hospitals in America that is provided by one of the national news magazines. There's a book listing the best doctors in America. And the assumption that all physicians and all providers are equivalent in quality doesn't make sense intuitively.

What about the second assumption, that sick patients will behave in a random fashion when accessing health care. A moment's reflection only sufficiently long enough to consider what each one of us would do if we were personally seriously ill would make clear that the second assumption is also false.

When sick, each of us seeks out the highest quality health care we access. And there's reason to expect almost all patients will do differently. Notice that for the purposes of my argument, it is not required that there be a difference in quality between one health care provider and another, although I'm assuming that there is.

What is required is that there be a perceived difference in quality. How many examples could be given? I will content myself with only a single one by way of illustrating.

Our academic health center has about 4,000 pediatric lives. In that pediatric population, there were 17 patients post heart transplantation by the time about

24 months ago when there were only 150 such patients worldwide.

That is to say that we had been adversely selected to the extent we had 10 percent of the world's population of post-pediatric heart transplant patients. This is clearly adverse selection with a vengeance.

But it is only an illustration, because children with heart transplantation are highly specific, and they're an inherently limited group, and Loma Linda is known worldwide for its expertise and its treatment of this particular problem.

I'm not sure that quoting these kinds of statistics proves anything more than certain patients will congregate in certain institutions. And indeed, if that were the extent of our problem at our academic health center, it would be easily manageable by an institution of our size.

The problem is far deeper and more pervasive than that. But in order for me to make my case, I'll have to turn more humdrum data, such as bed days for 1,000 patients. We have 30,000 commercial lives that are receiving their care at Loma Linda.

Most of the patients who signed up knew that they were signing up for care in an academic health center. I said that most of them knew that, but by a quirk of fate, 10,000 out of the 30,000 did not.

Approximately, one-third of those patients arrived at Loma Linda unintentionally. That is, they

chose another group of physicians and another hospital, but in the course of contract negotiations, the contract for their health care was transferred to us.

The latter group has received its health care at Loma Linda now for more than 36 months. Since the statistical measure of bed days per one thousand enrollees is often used as an indication of utilization of health resources generally, and since it's one of the most expensive of those resources, it will be used for comparison.

If you'll turn to the table, it's labeled two health plans and then academic health center. I realize this morning that my use of the term plan and group and provider is a little behind the times. Clearly those terms have specific meanings to the members of this task force. I'm more used to dealing with curriculum and things of that sort. I'm in error.

These are two groups. Group A and Group B. Of the 30,000 lives, Group A came to us by accident. As I said, they originally signed up for another hospital and another group of providers. But we looked after them for three years, and their bed days per thousand have averaged during that 36 months 164.

For Group B, these are the patients we have received from the five major HMOs that surround us. Their bed days per 1,000 are 264. Now, that's significantly different.

Their average length of stay is the same,

these two groups of patients, but the admits per year are obviously different. 4 percent of Plan A in any given year will spend a day or more in the hospital and 7 percent of Plan B.

Remember the patients in these two groups are being treated by the same group of physicians. The physicians do not know the group that any particular patient belongs. Nor are the differences due to failure to admit patients who should be admitted in Group A. Were this the case, once admitted, their length of stay would be significantly longer in view of the delay that would have occurred because they deserved to be admitted and weren't.

Given the same length of stay, the same group of treating physicians, and the fact that the health care providers are effectively blinded with regard to the health care plan of any particular patient, the only remaining conclusion is that there are significantly fewer sick patients among the 10,000 who signed up for their local -- for their health care with the local community provider.

The number of sick patients out of that 10,000 enrollees in Group A can be calculated. These sick patients can be matched with those contained within the 10,000 patients randomly selected from Group B and the difference in health care costs can be determined.

In Group B, out of the 10,000 enrollees, approximately 350 to 375 patients have been responsible

for more than 95 percent of all the bed days observed in any given year. Each one of these 375 patients thus utilizes or consumes the premium paid by 27 patients.

Now, patients are constantly moving from one HMO to another. For the most part, if the patients are healthy, this movement is random. Nor would there be a problem if as a result of this random patient movement 27 healthy patients moved to a provider that was perceived to be a high quality provider for every sick patient.

Unfortunately, it is only the sick patient who feels any non-random pressure. The healthy enrollees are not even thinking of health care for the most part since they are not utilizing it.

And the impact of each sick patient who moves towards a provider of perceived higher quality is enormous. For each one that moves, the receiving provider will experience the impact of 27 patients, but receive the premium for only one.

The provider from which the sick patient moves will likewise experience the 27-fold magnification of the event. Only in this case, it is as if the health care needs of 27 patients were no longer the provider's responsibility but the premiums continue to come in.

While the movement of one healthy patient is inconsequential, movement of one sick patient will remove the 27-fold benefit from the provider who loses the patient and a 27-fold penalty upon the provider that acquires him or her.

Now, in this discussion, I've only addressed the active component of adverse selection. The statistical component, that is, the patients who select an academic health center simply because they've always received their medical care there is another matter. It's equally serious. But I will not address it at this time.

This problem must be successfully addressed if we are not going to penalize quality in our health care system. The payment cannot simply accompany the patient, but then we're back to a fee-for-service program with all of its inherent disadvantages and problems.

They cannot be solved at the present time by either the HMOs or the academic health centers under the present legal climate. The laws mandate freedom of choice and unhindered patient mobility.

Imagine the outcry from those providers surrounding an academic health center, if the HMOs announce that because of adverse selection, they would go to increase the per member per month payment to the academic health center by 50 percent and decrease the per member per month payment to the remaining providers by an equivalent amount. Yet, it will require a shift in payment of this order of magnitude to level the playing field as I propose to show.

To allow freedom of choice and simultaneously preserve the cost containment and capitations without penalizing quality providers requires mechanisms that have thus far not been described much less

implemented, although the risk adjustment is definitely a giant step in the right direction.

Lay out the scenario a little further. Suppose that the sick patients constitute only 5.5 percent of enrollees. In actual fact, they constituted 4 percent of one plan and 7 percent of the other.

Now, assume that the same quality of care at the nearby academic health center induces one-third of those sick patients to leave their usual providers and move to the academic health care center.

There will only be a 1.5 percent loss from the enrollees of the surrounding providers assuming equal size groups. More realistically, the effect on surrounding providers will be blended by the larger numbers which they serve.

In our case, about 150,000 enrollees for commercial lives in the surrounding providers about 30,000 in our academic health care center. The effect of this is that the surrounding providers will only see a 0.3 drop in their enrollees. That is something that is mathematically and practically not detectable.

Meanwhile, at the academic health care center, the 1.5 percent gain in numbers is numerically detectible, but probably only barely. It will, however, increase the cost of providing care, including not only Band-Aids, but pharmacy bills, medical equipment, etc., to a level of 50 percent higher.

But under these circumstances, it adds

insult to injury for managers of surrounding IPAs to say we can provide health care for a lot less than you in the academic medical center and we can prove it. The answer is of course they can. And the reason is because of this patient migration.

If we match the 10,000 lives in Group A with 10,000 lives randomly selected from the 20,000 commercial lives and the remainder of our affiliated plans, we can do a relatively straightforward back calculation.

To determine how many sick patients have transferred from surrounding plans into our academic health center associated plan in order to account for the difference in bed days observed. The answer is that only about 150 sick patients from surrounding plans have moved.

Assuming that the average patient for commercial life in our region is $75, which is pretty close to the truth, the actual payment to the surrounding plans for commercial lives should be $67.50, while to level the playing field to the academic health center should be $112 per member per month.

Such an enormous payment differential is -- it was surprising to me when I sat down and calculated it. We talked about risk adjustment in large plans this morning, and that turned out to require the movement of at most 1 percent of the premium from plan to plan.

But if you have a provider such as an academic health center that accumulates a large proportion of sick patients from the surrounding providers, then for

that small group of patients, the premium adjustments need to be very large indeed. I say small. 30,000 lives is not trivial.

To conclude, as long as patients perceive a difference in quality anywhere in the health care system, they are free to move to take advantage of that perceived difference in quality. The system will in time self-destruct.

Higher quality providers who are perceived to be such will be penalized for their higher quality reputation since payment no longer travels with the individual patient. Instead, payment is allocated on the demonstrative false assumptions of chemo lab patients and a lack of qualitative differences among providers.

Directed by this imbalance, the equivalent premium payments of a population of 27 enrollees must also be transferred with one sick patient who moves from one provider to another. As we've seen, this is unlikely to happen by random movement of patients generally.

Where a perceived quality difference does exist, the movement of as few as 1.5 percent of the enrollees, provided they're all sick, to a provider of higher perceived quality will increase by 50 percent. 50 percent, the cost to that provider, in comparison to the provider from who those sick patients came.

Failure to address this incapitated managed care will destroy the health care system by unfairly remunerating providers who are perceived to be a lower

quality of expense than those who are sought by sick patients for meeting their health care needs.

The next slide, after the group plans are the distributions of the monthly bed days. The second group, there are patients accumulated from five different HMOs where, as I said, the first group is much more cohesive and has a much lower standard.

And the final graph just simply shows areas under the curve, the actual cost comparisons between the cost of maintaining patients in our two plans, and I use the two plans for the obvious reason, to compare it. A very nice control group since they're being cared for by the same institution, by the same physicians, and the physicians are claiming that they don't know who's coming from which plan. And finally, the per member per month payment required to even out this difference, as shown on the final slide, turns out to be the difference between 67.5 and $112.5. Thank you.

CHAIRMAN ENTHOVEN: Thank you very much, Dr. Bull.

Next, we'll have Dr. Jeffrey Huffman, President and CEO of USC's medical care group.

Dr. Huffman.

Ron, did you want to ask a question?

MR. WILLIAMS: Yes. I actually have a couple questions clarifying, so if we have the debate, I could understand it.

Dr. Bull, is the academic health center,

does it have a limited Knox-Keene license? Is it receiving capitation payments for both the professional component and the hospital component of the expense?

DR. BULL: The answer is more complicated than I can give you simply. But for the purposes of the discussion that I showed you, this was the total payment for professional and primary care.

MR. WILLIAMS: I guess the real question that I'd like to just try to understand centers around the limit that we as a health plan see ourselves in. That what these numbers argue for is really the fact that there is an insurance function that really ought to insulate the individual providers from the level of volatility and risk that those members suggest, and that most health plans would typically have stock loss arrangements for enrollment protections that would ensure that an individual provider would have a very narrow level of exposure both in terms of professional expenses of physicians as well as hospital expenses for use of the hospital inpatient/outpatient facilities.

And one of the things we have a lot tension for the groups who eliminate those enrollment protections for stock loss provisions and take the capitation payments and assume the risk for this kind of volatility, which obviously with your observations, that's the purpose of insurance or a risk-bearing entity.

And I'm just curious that if you take into account the concept enrollment protection and stock loss,

that while the data may suggest this, is the actual academic health center experiencing this or is there a health plan that stands behind the center and says you've gone through a corridor of too much risk for your entity?

MR. BULL: The answer to that is that the health plans are just beginning to acknowledge their responsibility for patients that are transferring in the middle of the course of treatment. But they are not yet willing to acknowledge that because we exist. The payments that are being made to the providers that surround us are larger than they should be.

We just recently actually dealt with the question of patients transferring in the course of treatment. So that's a fairly egregious -- these are patients transferred out of ones provided to us halfway through studying treatment for prostatic carcinoma.

That does address only that small portion of adverse selection. But we have a adverse selection problem as well, which I mentioned. The fact that we started with a population of patients we were treating to begin with in managed care.

And what is happening is that we see patients in consultation. The patients, a very major course from the local health plan, a very major course of treatment is necessary. The next time we see the patient, they've transferred into our plan.

Now, that happens to us probably three times a week, even as we speak right now. There's no attempt

made to rectify that. And in fact, the most egregious example is the patient who signed us up for their primary care provider lived in Puerto Rico.

After having been seen for the first time by one of our primary care physicians, it developed that he might have prostatic carcinoma, and sure enough he did have prostatic carcinoma. He was treated for prostatic carcinoma and two months later returned to Puerto Rico.

MR. WILLIAMS: I guess the question I'm trying to understand is that typically a medical group or a hospital has only so much exposure, and I'll pick a number. Assume it's $5,000. Doesn't matter whether the number was with another group or went to your group, that group can only experience $5,000 worth of expense before those charges shift to the health plan. Is that the kind of -- I mean, typically, that's the way it works. Unless the center itself is asked to take more of a risk. That's really the issue I'm trying to understand.

DR. BULL: I'm sorry. The center itself is taking the risk. The stock loss provisions only affect the very highest expense category. But if you go through the -- for prostatic carcinoma, the statewide average is 100 patients per 100,000. We have 300 patients per 100,000, and the group is accumulated around us.

Now, those aren't going to be hospitalized. But they're going to increase the total health care cost. I was using bed days only as a fairly hard figure that we do have access to. Because the figures you're asking for

would require much more complete data sets than I think anybody has at the present time. We just happen to have by accident these two groups of patients, and the bed days are dramatically different.

CHAIRMAN ENTHOVEN: Michael.

MR. KARPF: I think I'll pass a personal discussion with Ron. Clearly insurance companies have indemnified academic health centers to some degree, but I think that the track record is presently that stock loss is essentially being less -- it's less valuable because most insurance companies are trying to put more risk on individual providers.

So I think if you look at your own corporation, I think, and look at the contracting policies, you'll see that stock loss provisions deteriorated in their value as a safety corridor, and that you're aggressively pushing more risk for complicated care, not only on an incident basis for hospitalizations, but on a temporal basis for care over a year, which really has very considerable potential circumstances for a academic health system.

CHAIRMAN ENTHOVEN: Okay. Thank you. May we proceed? Dr. Huffman?

MR. HUFFMAN: Well, we very much appreciate this opportunity to address this task force this afternoon. We will address these issues, talk about a couple of threads, and maybe a couple solutions as we go forward.

I was thinking earlier that the institution is 115 years old, and I was wondering if they were having these same sort of discussions back in 1897 regarding changes to the environment, changes in the technology that have come up 100 years later. And I think some of these developments are par for the course as one tries to continue its public benefits commission.

Some of the potential threats that we've identified, other speakers talked about, but I think repetition is healthy here. Prepaid Medi-Cal, patients being recruited out of our system, the L.A. County system, reimbursements well below cost, and also prepaid Medicare, which is a large percentage of current payer mix, 30 percent, and most of those patients currently have a choice that come to us, and a percentage of the plan is obviously increasing as we've heard.

Changes in our structure -- well, unlike our academic mission, which has been around for 115 years, our private practice mission is relatively new, for new entrants in the market. The practice plan was evolved in 1984, and it wasn't until the Norris Hospital was built in '84, '85, and the University Hospital in '91 that we really got into the patient service.

However, we have incorporated a arm's length group from the University USC Care Medical Group two years ago. This is an organic non-bureaucratic group that allows us to make changes more rapidly from that subject to the typical academic slow process.

We have tried to integrate the practice group for faculty. We have 450 specialists. It's a big group to try to manage. We've tried to have common systems, common functions, and focused strategy. This is a bit problematic in that we do not receive a premium from those groups for taking care of their patients, which typically are very sick patients.

And so thoughts about risk adjustment are really welcome to us. We have succeeded in getting our practice and costs down. And that's allowed us to compete favorably in this market.

Our patient volumes increased. But when you look at this, what's happened is the faculty for the most part are the ones that are good at delivering service. They are also the ones that teach the undergraduate students. So as they try to compete more in the private side, less time is being devoted to the educational side. And I think that's a critical problem as we move forward and as reimbursements continue to increase.

Now, obviously, this is a very complex problem with prepaid Medi-Cal in my area, but we do have patients recruited out of our system, billboards next to the medical center, recruitment going on on the sidewalks, and this obviously has had a negative impact on LAC USC finances.

We've had a long relationship with the County of Los Angeles and our medical faculty is the medical staff at the medical center.

On the private side, we do take care of Medi-Cal patients, reimbursements well below cost for hospitals, and physicians will absorb the cost for a portion of these patients, but there are limitations to this. Frequent changes in eligibility add to administrative overhead and delay payment.

One possible solution and what we've talked about a lot before is that partnerships for primary care can stay within the LAC system. We do not compete on the private side. And selective procedures like organ transplants and the other high level procedures, I don't think we'll survive if we continue to compete with the County system.

Going onto the Medicare, Medicare Part C, if you will, and I think this new capitated alternative is promising, but I want to point out some potential problems for academic centers. Part is the balanced budget act of '97, where organizations will contract directly with HCFA, the organizations must be licensed to take risk before 2002 provider service organizations can appeal for a federal waiver of this licensing requirement.

CHS is determining a level of capital reserve required to solve this. I think academic centers, particularly our group, will have difficulty competing with insurers and other large profit groups. But I think as we go forward, we'd like to be able to compete on each ground for Medicare risk patients also.

Some final thoughts. This has been said

before. I'll repeat it again. Patients, employers, health plans and all of society really benefit from quality education and medical research.

There's less NIH money, less public sector funds, lower physician reimbursements, creating pressure on academic institutions to sustain this benefit. I think one possibly will be to create all-payer fund to support undergraduate and graduate education.

CHAIRMAN ENTHOVEN: Is there less NIH money? I keep hearing that, but when I look at the actual data, it continues to grow.

MR. HUFFMAN: for us it's been less.

CHAIRMAN ENTHOVEN: Not national?

MR. HUFFMAN: I don't know about the national.

MS. BOWNE: I think the national figures are that it is keeping pace with inflation but not increasing, but it is certainly not decreasing. They could be true too and not causing it.

CHAIRMAN ENTHOVEN: Next, then, we'll have Dr. Kenneth Wolfe from the Edgar University School of Medicine.

Dr. Wolfe.

DR. WOLFE: Good afternoon. I'm passing around a copy of my statement and in an effort to stay within the time limits, we'll go over to the slides. Thank you for the opportunity to present for you this afternoon. The Edgar University School of Medicine is the

academic arm of Martin Luther King Hospital, a large county hospital in South Central Los Angeles.

The rapidly changing health care environment has had tremendous ramifications, not only for the providers and hospitals, but also for academic medical centers, and particularly individual faculty who are charged with educating future health care providers.

We as faculty need to understand this new system in order to be effective teachers as well as effective deliverers of health care education.

The method of reimbursement impacts the way individual providers practice. Under the traditional fee-for-service system, payers wanted providers to do as little as possible to keep payer costs under control.

On the other hand, providers wanted to do as much as medically justifiable to maximize the revenues. This retrospective fee-for-service system was ideal for the academic environment. It fostered the request for the unusual, fascinating, highly unlikely or fairly rare disease or condition. There was no financial penalty or disincentive for such investigation.

By contrast, under capitation, payers wanted providers to do as much as possible because their payments to the individual providers were fixed. Providers, on the other hand, wanted to provide only the minimum amount of service required to meet their medical responsibilities.

Payers also started to demand accountability of outcomes for expenditures. Under the prospective

payment systems, with justification requirements, the economic disincentive for academic medicine becomes a very significant and major issue.

If individuals without -- with rare diseases cannot turn to the academic medical center for their care, where will they turn? Academic medicine has been said to be slow to respond to the challenges of managed care.

Myers and Associates recently stated that it really wasn't a question of compatibility of missions. Academic medical centers traditionally educated health care professions and conduct population-based research.

Managed care organizations deliver health care primarily to defined populations. Those narrowly defined populations allowed them to control costs in a manageable way.

This incompatibility of missions has not been an issue until the recent changes in the economics of health care delivery. And with these changes, we are now seeing across the country a number of mergers between academic medical centers and managed care organizations.

Well, what do these mergers and partnerships mean in terms of the faculty structure within medical schools? For example, someone asked if managed care organizations would be allowed to deselect senior faculty whose practice styles are simply too costly for the managed care organizations existing practice guidelines.

Will the emphasis on financial productivity be the basis for junior members academic advancement?

Will the world of academic medicine be based on academic productivity or on economic productivity, and what will this impact have on the delivery of education, as well as on research?

Two recent reports came out in JAMA earlier this year. One by Campbell and Associates reported increased competitiveness in health care markets seems to hinder the capacity of academic health care centers to conduct clinical research as well as to foster the careers of young clinical faculty.

In that same issue of JAMA, Moya and Associates reported that over the past decade, there has been an inverse relation between the growth of NIH awards and managed care penetration among U.S. medical schools.

Even though academic leaders are attempting to do their best to maintain academic productivity stands, it appears as if economic considerations are indeed affecting academic productivity. Will this trend continue, and if so, what impact will it have?

Despite the changes in medical practice that have taken place, there has been little, if any, change that has occurred in medical education on graduate medical education. Last year their survey revealed that 22 of 125 medical schools required students to have experience in an HMO. 55 of the medical schools offered some of the students an experience in an HMO.

In general, medical schools used managed care organizations to train their students because they

were good clinical sites with rich clinical databases, not because they offered some unique environment in which to train their students.

Historically, from the perspective of the HMO, having medical students and residents rotating through their facilities tend to increase operating costs and lower productivity because it takes time and money and resources to maintain a training program.

This is not new information to the academic medical centers, as they have long known that efficiency and productivity may be compromised by their mission to teach. Managed care leaders report the graduates of our academic medical programs are not prepared to enter the managed care world.

They estimate that it takes at least a year or more of post-residency training experience to participate effectively in the managed care environment. The concepts of managed care, cost effectiveness, health care delivery, need to be interwoven throughout the educational process.

For example, students must have the academic grounding in epidemiology and statistics to be able to move into an evidence-based clinical practice. They need to understand practice guidelines and also how to modify these guidelines leading to improved and measurable treatment outcome.

The physicians have to be trained in the financial concepts of health care so that they will not

simply cut care, but rather make the cost of care more effective.

It's our philosophy that preparation for the managed care environment has to occur throughout the medical education, continue reaching undergraduate medical education, residency training, and faculty development.

Our undergraduate medical education program has a primary care core requirement throughout the entire third year in which the students must attend weekly lectures on the social aspects of health care.

As part of that weekly series, there are sessions that include managed care, health care financing, epidemiology, evidence-based medicine, and other areas directly related to managed care.

In addition to the didactic series, the students are required to participate one half day per week every week in a continuity of care clinic where they are exposed to some of the very same concepts.

All of the residency training programs are augmented by a bimonthly college and medicine program known as academic development for chief residents. One of the workshops in this series is devoted strictly to managed care and concepts associated with it.

And it must be remembered that most of the faculty began their training and, in fact, their practice at our health care delivery system that was vastly different from the one in which the graduates will be

entering.

Therefore, a faculty development curriculum on managed care has been created that will begin later this fall or in winter. The faculty development series will include such areas as health care economics, accountability and treatment outcome, teaching research and ethics in the managed care environment.

By doing so, we believe that the faculty, the residents and the students from our institution will be prepared to enter into this new health care environment.

In conclusion, I'd like to turn to the words of Jordan Cohen, who is the president of the Association of American Medical Colleges, who recently stated, the imperative for medical education is clear. Students and trainees must learn not only to practice the best medicine, but how to best manage in limited clinical research.

CHAIRMAN ENTHOVEN: Thank you very much, Dr. Wolfe I must say it's refreshing and very positive to see a description of an academic medical center really focusing on the new environment of managed care.

As you noted earlier, that's unfortunately still the exception, and Dr. Cohen's concluding remark is certainly right on target.

DR. WOLFE: I have to tell you, the session we began with the residents last year was the largest attendance of residents, and it's the only one that I know

that nobody left early. The residents are very concerned about this information.

CHAIRMAN ENTHOVEN: That's great. Bruce.

MR. SPURLOCK: I also want to appreciate Dr. Wolfe for your presentation. I think it really does hit on a key thing about managed care, which is not just the marketplace but the environment, which I think is a critical component of the teaching mission that all academic medical centers have to teach -- focus their charge on teaching.

I'm just curious, you know, since you've gone that step and you've talked about epidemiology and outcome based -- if you've taken that step as well as a leader to look at what outcomes you've had from the changes in the curriculum, what kinds of results you're receiving from that.

Are these students then more able to adapt than they were five years ago? I would assume that if people got trained in the community or trained in the HMO settings, that there may be cost shifting that you might be having in your medical center. I wonder if you look at those kinds of outcomes as a reflection of the success of your curriculum, which makes, you know, eminent sense to me.

DR. WOLFE: It does make sense. Unfortunately, the programs are all still too new to have any information that would tell us that. But that is the objective.

MR. ALPERT: I'd like to ask all the panel members, at your institutions have the situations you've described translated to a palpable movement of the most qualified or some very, very qualified clinician researchers and educators from that environment to the private environment because of the -- of the seemingly added impact on academic medical centers economically because of the, for lack of better way to say it in using today's topic, lack of risk adjustment in your patient population, which translates to less money to the centers?

MR. GURTNER: I'd start, I think, first of all, the movement of faculty to the private sector in this market is slim to none. This is not the solution to the faculty problem. But there is a lot of movement, and let me just speak to that briefly.

I think that -- and maybe going back to Ron's original question. I think there is a recognition, and you will find that in all these systems, several things that have happened.

One is a substantial increase in primary care activity and training. Secondly, we are all very aggressively involved in community training in the ways that ten years ago would have been unheard of. Third, every one of these academic centers really across the country is in some method or mode beginning to integrate with community physician groups.

Now, that goes back to Ron's question. The reason that has happened, managed care has brought that

up. The fact is that the vast majority of patients are now at a risk level controlled by community physician groups.

These used to have the -- the faculty used to have access to these patients. Because as was said at USC, you've got 30,000 attached to the university and 150,000 in the medical group next door.

So the need for faculty to integrate at the academic level is very potent, very strong, and is more or less successful in various ways. But where the university has found itself in almost every case is that the risk level Ron was talking about in terms of who takes that and how well people are protected, has really dropped a whole level from the academic centers' point of view.

Most of that risk and potential reward has dropped to the local medical group, not directly to the faculty where at one time it sat. So in order to participate, both to protect themselves and to, in fact, have access, and to benefit from some of that, clearly the faculty is moving out into the community physician side.

At the same time, if you think back on an economic base -- and I'm a little off your question, but I didn't want to comment on Ron -- that the whole economic structures, certainly the institutional level, and we've now added a physician dollar too, but was based on a stock loss at one end and a broad distribution of average payments on the other, so that the average institution or organization saw inexpensive cases and very expensive

cases, and they had an average price.

But over time, historically, two things have happened, and it's been because of the pressure of that physician -- community physician group and the local community institutions.

The range of payment has dramatically declined, and stock loss protection, which was in place at one time to protect against this high cost -- and, actually, to go back in history, the academic medical center was probably responsible for the development in many ways of the whole concept of stock loss. But that has now grown so high that it becomes stop loss for the mountain tops, and the range has become so narrow that there is no excess protection at the other end.

You put those two together, add the incentive of the local medical group to shift the expensive high-tech case to the faculty, to the need of the faculty to participate at a community level, you have an incredible catch 22. The faculty now knows in the universities that they can't ignore managed care's access to patients. They must participate at the community level. They know that.

They also were -- they also know that the care delivered tends to concentrate in that academic medical center relative to high-cost cases. That's true. It happens. It would be that the medical groups wanted there. There's lots of reasons that that happens. But the problem we're all talking about here is the system has

not adjusted for that difference.

Now, if we're going to train the next group of physicians in the community to be community responsive to be managed care friendly -- that's a term that I find marvelous because I'm not sure what unfriendly is, but managed care friendly, we have to recognize that there is a cost to that.

Anybody who has gone out and done the community training now, and we've done it. Fresno is the best example. Large numbers of community office training. Riverside is another example. What we're finding is, number one, it's more expensive, and the community physicians who used to volunteer their time at the academic medical center is asking to be compensated.

So we're, in fact, adding cost to the system at both ends to respond to the needs of the managed care marketplace. Long-winded answer, but I think the fact is the academic faculty are making the move, but we're still caught in this vice of no economic realities to that move.

MR. HUFFMAN: One other comment, as the community-based groups are merging or partnering with the academic medical centers as an ambulatory site for students to be able to rotate and get experiences, there is a greater request for many of the community physicians to want academic appointments.

Just because a clinician is a top quality clinician doesn't necessarily mean that they can meet the standards and that they are good teachers. And so you've

got this compromise and new categories of faculty that are being considered and created, and that creates another stress on the system.

MR. GURTNER: I think it's safe to say that research in academic medical centers has decreased, but it's probably a kind of a research that was done on the margin. The well-funded researchers from NIH are still getting funds, and the basic scientists are still getting funds.

What has disappeared almost entirely are the small studies that were done with a small number of patients and a fairly quick -- the kinds of things that you did on the margin you didn't worry about applying for a grant. Those have essentially disappeared. And the reason is that the faculty is working a lot longer and harder.

Another thing THAT has disappeared, almost disappeared, is the willingness of community providers to accept medical students. They're under sufficient pressure now that they -- they want to be paid simply because it takes them a fair bit of time and money to teach, and they're being pushed. And those are the things that are hard to quantify. But research grants, big ones, I don't think have dropped off significantly.

CHAIRMAN ENTHOVEN: Rebecca?

MS. BOWNE: I wanted to change the topic a little bit to something that I was surprised none of you addressed given that one of the major missions of an

academic medical center is training physicians. And I notice that none of you spoke to either the number of physicians that you're training or the mix of specialty versus primary care.

Before we get into that, I was very struck, Dr. Wolfe, and really pleased with what is being done at the Drew Medical Center, but it strikes me even stranger that in this day and age that only about 55 percent of the 125 national medical schools are either requiring or even offering experiences in HMOs.

And hopefully with the changing Medicare reimbursements starting in '98, that will allow a portion of the payment for when physicians are training in ambulatory rather than just the academic medical center. Hopefully, money does help change lines occasionally. But I would like to have you address the issue of the number of residents that are being trained, the number of physicians that are being trained, and that mix of primary specialty care.

DR. WOLFE: The study by Velaskeyev that was published last year from the LCME questionnaire, it's a questionnaire from the liaison committee on medical education that came out. It is dated and at least two years old now, even though it just came out. I know there's another study that is in process being collected by a different group of researchers, and hopefully that information will change. Drew is a little bit different seeing that our primary mission has always been primary

care. So we're not seeing many changes in terms of where our people are going.

As to the number of physicians totally being trained, the output of American medical schools has actually declined over the last decade. What has happened is that the number of physicians entering the work force has been fueled by far more medical graduates, and that has skyrocketed. Actually, there are fewer medical schools now, and they're graduating fewer students in American medical schools than they were 10 years ago.

MS. BOWNE: If you look at the statistics in the UC system, I think you'll find that they're training at least the same number if not more.

MR. WOLFE: I think they're probably stable. But the total of work force has increased by about 30 percent.

CHAIRMAN ENTHOVEN: Well, just to follow up with that, could we agree that some -- given the pronouncements by the great authoritative bodies, could we agree that some reduction in the output would not be harmful for the future of American medicine?

MR. GURTNER: I'll attempt that one. I think that's a nicely put comparison. I think that Dr. Werdegar could give us more input into the current status of change. I, for one -- there is an agreement with the state in terms of what it is anticipated to do. And as you know there are five campuses, and each of those are different. It would be interesting to see if the changes

at the federal level of providing some economic incentives to look at these numbers will have an impact. My guess IS it will. We'll have to wait and see what happens.

CHAIRMAN ENTHOVEN: Yes. Rogers.

MR. RODGERS: I appreciate the panel's presentation. Having one academic medical center in Arizona, I can appreciate what you're going through since the Medicaid program was under managed care and all the challenges you face. There were some realities that we face, and it was a question of compromises and the willingness of the academic community to compromise some things that they had held very dear.

For example, residents versus individual residency programs. Integrating residency programs to reduce overall cost. But the one thing that we had the most difficulty with was choice.

Once you give the person a choice of where they go, which has not always been important even to Medi-Cal individual fee-for-service plan, they've always assumed they can go to County. They haven't always assumed they can go to private doctors. Now that they see they can go to private doctors, they say they don't want to go a residency training clinic.

They know that somehow, even as you move to primary care, your greatest challenge is to still engage the member, because they know that you won't be there, the resident won't be there the next go around. And that was the greatest challenge.

And so if there is anything that I would look to, not so much specialized treatment, as much as everybody raising their hand, (inaudible) and is usually at the forefront of the specialized treatment. But it's the primary care, the medical home of the individual patient where that member meets their primary care physician, and we haven't been able to successfully engage in our academic medical training programs.

MR. WERDEGAR: Alain, I was just going to comment --

CHAIRMAN ENTHOVEN: I just noticed our court reporter is saying she needs a moment to change some paper.

I think what I'd like to do is take advantage of that opportunity to introduce Dr. Joseph Hopkins from Stanford Health Services. Welcome, Dr. Hopkins. Sorry we've gone ahead without you. Could we pull up another chair.

If you could summarize quite concisely the key points. This morning we had an extensive discussion about risk adjusted payments and the importance of that. I hope and trust and believe that there's a widespread support for that idea which would help to correct some of the --

MS. SKUBIK: Just a timing note. The doctor/patient relationship people are saying that they would like to give up their time and schedule for next time so that this gentleman can have his chance --

MR. GILBERT: So we have enough time.

CHAIRMAN ENTHOVEN: Oh, yeah.

MR. GILBERT: Because we think it's too short. We've gotten too short into our time.

MR. HEILPLER: If that helps you reallocate what you need to do.

CHAIRMAN ENTHOVEN: In view of the fact that we have a speaker from Stanford, I think it's very important --

MR. HEILPLER: We thought that might be important.

CHAIRMAN ENTHOVEN: So, if you could, and the question, if you hadn't appeared, I was going to ask the panel is beyond risk adjustment, for which I trust there is support, including the risk-adjusted patients flowing through the providers, is what other specific recommendations are there to -- I don't want to say ease the plight of the health academic centers because I don't think it's our role to, you know, placate an interest group here so much as to pursue the public interest. So --

MR. KARPF: Appreciate appropriate function.

CHAIRMAN ENTHOVEN: So what recommendations, in order to encourage and reward the valuable products, while at the same time encouraging the transformation to a more efficient --

DR. HOPKINS: I have some ideas about that. I regret that my problems with airlines have prevented me

from hearing the presentations. So I'm going to move pretty rapidly, and you can slow me down or speed me up as we go through this.

I'm sure you're all aware of the triple mission of academic medical centers. But I think it's not well-appreciated in the public, and it's probably already been touched on the degree to which the three are funded in different ways. But the funding of all of those things actually interact in ways which funds all three of them in the aggregate patient care revenues, which is the part that is most immediately impacted by managed care, according to the AMC, currently make up almost half of the support of academic medical centers, and that has grown by more than double as a percent since the early 1980's.

I wouldn't put up this as one of the problems that I identify that I don't know how much has been touched on, but I believe there is a problem for the public with access to academic medical centers for certain kinds of care.

We certainly experience that on almost a daily basis with people seeking care at our institutions, but unable to get authorization to do that and have had some anecdotes that I won't dwell on, but which I think were not ideal care.

We do have, I think, academic centers have some unique capabilities in patient care that should be taken advantage of, and not always think that everything can be done at the local level.

We have analyzed our adverse risk using the methodology of the health insurance plan of California, which I'm sure some of you are familiar with. Basically, that methodology looks at the prevalence rates of very high-cost, complex diseases in a population, such as things like cancer, heart disease, congenital anomalies, multiple sclerosis and so forth, and when we look at our population at Stanford, we currently have about 36,000 patients who are fully capitated to us.

When we look at that population of 36,000, we find that the prevalence rate of those high-cost complex diseases in that population is 11.41 per thousand compared to 3.27 in the overall state population that are included in that methodology.

In other words, three-and-a-half times more of those diseases in our population, because patients elect to come to us who are sicker because they think they need care, and I'm talking here about the people who choose us for all of their care, their primary care, secondary care, tertiary care.

When you factor in the weighing factors you can do from the HIPC methodology to look at what is the predicted, not the actual cost, but the predicted cost of the care of our population, it's 23 percent higher than the population at large. You won't be surprised to learn that our capitation rates are not 23 percent higher.

Another thing that's occurring, because of the flexibility that has been given to the public to move

around, which is understandable from their point of view, but creates enormous problems for us in a financial sense.

Most of you know people are not able to choose for their primary care location or comprehensive care location anyplace which is within 30 miles of their home or their work. People work sometimes long distances from their home and are more likely near AMC than not. And their home is likely to be.

In addition, market forces have produced the ability for people to change plans every 30 days. So what happens is that people float along quite happily in their local medical group until something major comes up, and then if they happen to work or live within 30 miles of us, which is a huge number of people, they will simply transfer their care over to us, get done whatever they need to have done, surgical procedures, cancer treatments complex diagnostic workups, bone marrow transplants, and so forth, and then when all that's over, go back to the local medical group.

The way capitation works is that it comes every month. So the bulk of the money then is before we ever saw them and after we saw them, and a little bit comes to us as a month or two of capitation.

I wanted to comment on our experience as far as the impact on education. I think most of this derives from the fact that due to the declining patient care revenues, which are a critical part of our operation, physicians are being asked to see more and more and more

patients, such that they have less time for academic pursuits.

In our own case, we have lost five general internists, one of whom have received several teaching awards, simply because as they become busier and busier, they no longer see much difference between what they're doing and what people practicing in the community do. And so they see those people generally earning more and more money than you do as a faculty member, and so they give up and go practice because that's what they're asked to do anyway. Furthermore, there's less time for the people that stay.

You may not know that a lot of teaching, particularly in primary care that someone asked about, occurs from what we call voluntary clinical faculty. These are people who practice in the community but give their time free to help teach students, let students learn their offices. Particularly, this is important in ambulatory settings.

We are experiencing, both in family practice and in general internal medicine and in pediatrics great difficulty getting those physicians to have our students train with them because they're too busy. They also are being asked to see more and more patients.

And yet these are the very primary care sites and ambulatory sites of training that we are being asked to address, and it's been mentioned here as well. And those sources of training are now getting hard to find

because the people are too busy.

Was this study on NIH grants already talked about?

CHAIRMAN ENTHOVEN: This was referred to.

DR. HOPKINS: This is a very interesting study that was just published a couple of months ago, and what it looks at is the rate of awarding NIH grants for clinical research -- I'm talking in this particular case about basic research -- clinical research to accommodate medical centers, and it's broken down based on whether the academic medical center is situated geographically in an area of high managed care penetration, which is the dotted line, medium or low, which is the two other lines.

And as you can see, historically, the three sort of started out as being very similar, and as time has gone on, in those areas where managed care has a large penetration, the awarding of NIH grants is falling off. And in the last year of this study, which was 1995, that is an estimated loss of nearly $100 million in supported research to those institutions.

Now, why should that be? I see you shaking your head, wondering what -- well, a study that looks at one of the reasons why that may be goes back to the fact that people are asking to be doing more and more patient care to make up the losses in patient revenue, and they simply don't have time to do anything else.

This looks at how faculty members and clinical faculty members and, in this case, the younger

clinical faculty members, these are the people that will produce the research advancements for the future and will be teaching the future professionals.

Those people and looking at them of the stage of development now of the managed care market where the school happens to be located, among those people in stage one and two, 44 percent have significant clinical responsibilities. But as you move up into stage three, it becomes 56 percent, and then stage four, it becomes 86 percent.

And the amount of research and results that were produced as measured by the number papers that they are able to get published is going down as you move from stage one and two to stage three and four. This is very alarming.

What it means, I think, is that academic medical centers that are in very aggressive managed care markets are losing their research base, and this is just beginning to appear. We already know we were losing patient revenues, but now this is under threat as well. I'll just move to my conclusions.

CHAIRMAN ENTHOVEN: Losing patient revenues, but Stanford's patient revenues are rising.

DR. HOPKINS: The total volume is rising, but the amount relative to cost is going down. We currently collect about 44 cents on the dollar bill, and that's after -- that does not support the cost. It barely supports the variable cost of operating a medical center.

It does not support any of the fixed cost which are currently picked up by other payers. And that's after a 20-percent reduction in operating cost we've achieved over the last seven or eight years.

So it's not because we are not trying to cut our cost. In fact, there's been an enormous amount of reduction of cost. And still we don't get paid enough to pick up the cost of doing what we do. I'm just talking about operations there.

My conclusions, economic medical centers are extremely valuable resources. The triple mission of education patient care and research critically depends on patient care revenues to support aspects of all three, both directly and indirectly.

Revenues have been severely eroded, at least as a collection ratio threatening that mission. AMC's experienced adverse selection, which I think has already been acknowledged. Consumers seek greater access to AMC. That's our perception, particularly when they have complex diseases and want those treatments.

There are, in my view, insufficient guidelines at the present time to say when a medical group should refer a patient to an academic medical center for whatever the procedure is when it really is beyond local experience of that group.

Current laws and regulations created to allow patients a greater choice will result in patients being in and out of AMC's. And this leads to dramatic --

dramatic underpayment of sometimes $100 of compensation for thousands, multiple thousand dollar procedures at those institutions.

Faculty members are experiencing pressure to increase patient revenues and as a result are doing less educating and less research, and this, I think, is particularly a problem in primary care and the ability to get large research grants is much more limited. So those faculty are even more dependent on patient revenues for support in their other activities.

We talked about the decline in grants, and I think if this is going to continue, we're in big trouble. I do have some -- a couple suggestions, and I've tried to build on what I'm aware of as existing methodologies and procedures in managed care, which might be taking advantage of improving the situation beyond the obvious risk adjustment issue.

I think the issue of preserving access to academic medical centers is very important. There is an existing center of excellent concept where particular centers are identified, particularly in organ transplant and cardiovascular surgery as being the places that do that well and where you should go and everybody is sent there by convention.

I think that concept could be expanded to include more diseases than is currently done, and by agreement that those sorts of things should be done in academic centers, including the more complex to even some

of the common diseases perhaps. Although there is a lot of credentialing of physicians, there is very little credentialing at the level of how many of these do you have to do to be really good at it.

And that's often a difficult decision for referral of deciding does the local medical group have expertise or not. That could be approached through credentialing methodologies, which already exist.

There is some evidence in the literature about what it takes to be confident in some procedures, and at what point you reach the threshold where you really get it right.

I think there are opportunities for cooperation between community medical groups and academic centers in terms of designing paths of care.

We have those guidelines that describe the events, but they usually don't say what kind of physician or where these things should occur. And perhaps those elements could be added to existing guideline methodologies as a way of resolving when you should go where.

And appeals, although it's a cumbersome process for sure, might be strengthened with better understanding. One of the problems is the knowledge about new procedures often is available only at the academic center because a lot of these things, as you know, takes one or two years to get into the general medical literature.

The people making the utilization for these decisions are not at the academic medical centers. They may not have all of this knowledge. And if there is a way to get that decision made in a more informed way, it would help.

I think we need to be paid at the level of complexity of care that we're delivering. That risk adjustment is a possibility. There's also this problem of people moving in and out. Those people can be tracked from enrollment databases.

And I believe a different source of funding should be afforded us for those short time ventures with us. It's not appropriate just to pay capitation with that. And that should be paid either through reverting to the cost of the medical group from where the patient came or perhaps a central pool to which all groups contribute.

If indeed it's the desire to maintain the level of flexibility for people to move around rather readily as it currently exists, restricting that is another option. Probably not as popular, but would tend to help us from that perspective.

The idea that you get primary care 120 miles from your home just because that's the group that you wanted to sign up for your whatever is crazy from both a medical point of view and certainly from a capitation point of view.

And finally -- and I'm sure this has been touched upon -- if we really are going to take the

subsidies that come from patient care out of academic medicine, we've got to put them back in some other way, whether that be premium surcharges or different flows of money to those places, there are a variety of models that have been proposed at national level and state level, and so forth. But these organizations cannot make it with the dwindling revenues that they now experience, and those are my prepared remarks.

CHAIRMAN ENTHOVEN: Thank you very much, Dr. Hopkins. Questions. Comments. Dr. Karpf.

DR. KARPF: From my perspective, we need to instill these issues into recommendations with the task force to deal with in terms of managed care and not into recommendations that reflects societal needs.

There's a real difference between those two. There are a lot of societal needs that academic medicine supports that are very important and need to be addressed. But there are issues that managed care needs to participate in. So what we need are somewhat more discreet suggestions of what can be done.

Certainly, the issue of adverse selection is an important one, and I do have some relationship to an academic health center. I think Mr. Gurtner will attest to that. My academic health center was voted best in the west for eight years in a row, not seven years.

So what we need to do is get specific rather than general. The issue of adverse selection, I think we're starting to see a consensus in risk adjustment, how

to remunerate the process to some degree.

It's a really theological kind of issue because academic medical centers if they, in fact, are going to take care of most of the complex patients are always going to have the worst kind of adverse selection. But I think we're starting to see a process for dealing with that. It may not be complete. It may not be perfect, but certainly it's a start and a direction.

I am wondering if there are other specific recommendations that you might have. The issue of education is an important one to me, and I'm actually quite surprised that no one raised the issue that dollars that were intended on a federal level towards education and have, in fact, in the past been siphoned off by managed care organizations, whether or not that has been totally corrected by the recent Medicare legislation or whether, in fact, we need to address that as an issue in terms of how one supports discreet needs of education.

We certainly in academic medical centers push the envelope of care and the mechanism by which we translate research to everyday care. That's a very important contribution to society, but also one that every provider and every payer must share some responsibility for. I'm wondering if you would have some suggestions on how managed care might participate in that process.

DR. GURTNER: If I may start, couple comments. One is I believe for the first time this year at the state level, we finally have recognition of the

Medicaid program that medical education is important. How that works out, we didn't speak about that because, in fact, there is legislation, and we'll see how that works out, and I think that's a major step forward.

At the federal level, I think we have to wait and see. Clearly, we did not win everything that everybody thought should have happened. But it is a major step in the direction of recognizing in the ACCP there was indeed educational dollars that should come to us.

It's unclear how the HMOs will use that legislation, and I would -- if this group gets into the whole federal effect on HMOs rather than the state effect, I would hope they would challenge the HMOs to make sure that money stays on the educational side, and it is not contracted back out.

And I think that's an issue that we do worry about in this coming year as to how the HMOs will react to that. I think the other big issue other than what has been mentioned in terms of risk adjustment, which really came out very strongly in the Irvine discussions, which some of you may have followed in the last year, something needs to be done about access, in terms of protecting access to some degree. The fact is we have an educational system based on an institutional method of teaching.

It is changing. Everybody is moving to that. But we need time, and for you to -- we need protection of the educational system long enough to allow this new method, this new structure of teaching, which has

to occur in the ambulatory setting to fully develop, and I'm not sure that people understand that. And I would challenge the group that there are some kind of overarching issues that aren't specific, but are principals, that unless you articulate, will be lost in the debate.

The solution to the integration of managed care and education of teaching is not just specific changes of the managed care program. It's a recognition of policy level that there's an asset that must be protected. And as ideas and options come along, they've got to be addressed in that fashion. Not just are we going to save 12 cents per capita on X number of patients, because the 12 cents you save, as I hope we've demonstrated, may have cost you millions of long-term returns. That is a principal that can't be lost in this debate.

CHAIRMAN ENTHOVEN: Rebecca?

MS. BOWNE: Dr. Gurtner, I think we all have clearly -- if we didn't know before, we certainly know now that the intensity of services and certainly the tertiary services that the academic medical centers provide, and as new things develop, we want and hope provide an environment where you and Stanford and Loma Linda and the UC system would all be on the cutting edge of these. But I think what we would -- and time to protect, so to speak, to make the change.

But I think what we would ask in return,

which we have not seen in the past, other than a few minor exceptions, Drew being one of them, is a laid-out plan that is followed that shows that you recognize the time for change and do plan to address it. Because what we see is stonewalling -- you know, we're different than anything else. We're better than anything else. And the world has changed, and I think academic medical centers who clearly have our best and our brightest and our cutting edge and where we want that to be need to be changing with the times rather than stonewalling.

MR. GURTNER: I could find no fault whatever with the statement, but I'm not sure that the seriousness of the situation has been clearly laid out. The 20,000 patients that I referred to, if you accept my statement that they probably are adversely selected, given the fact that we have 10,000 that match the community rates, are costing our medical center at the present time a million dollars a month.

Now, we cannot support that for very long. That's more than our entire medical system makes in profit. That $10 million is coming out of the educational system. It has nowhere else to come from. It's coming out of the medical school, teaching.

So my plea to you would be if you are going to move towards risk-adjusted calculations, please do so quickly. Because failure to do that is bleeding the academic medical centers, and at this point in time, most of us have been bled so much that we do not have the

fiscal ability to do anything other than just sort of hang on by our fingernails if we expect to show positive bottom line. A million dollars a month is more than our entire medical system shows from operations.

CHAIRMAN ENTHOVEN: One question in the line of how to deal with this. From -- in the five years leading up to 1992, the premiums in CalPERS doubled. For a million people, about two-thirds of whom are state employees, and therefore that cost the state money, and the rest cost the public sector money.

From 1992 to 1997, the premiums have been flat. If the previous trend had continued, health care costs for the public sector employees covered through CalPERS, which is not the whole public sector in the state, would have -- would have now this year cost $1.5 billion a year more.

So in a sense, if you want to take the previous rate of growth as a standard, there are savings of one and a half billion dollars a year. Now, that was a time of extraordinary expense growth, and, you know, some may find it differently. But whatever you do, certainly it's the case that the public sector, just for its own employees, has saved a huge amount of money because of the effectiveness of managed care in controlling health care costs for state employees.

And I do wonder whether it's not appropriate for the state to recycle some of that back. Because presumably your financial needs to compensate you for some

of these revenue losses must be relatively small compared to the $1.5 billion a year.

Have you made that -- have you tried that proposition?

MR. GURTNER: I think -- in some ways, with Medi-Cal's recognition of medical education as a legitimate expense, I would say yes, the debate to some degree has begun. But I would urge you not to look at this as a pure economic issue.

Without that mass of clinical activity, without the patients, the whole premise of the educational system is threatened. I don't know how to say that any better. What we've done is not only saved these dollars, but moved them around the system and saved some.

But we've also, for a lot of very positive reasons allowed and encouraged the patient population to move around. And as a result, our access has changed, and that is as big a threat to the future of the system as the economics are, certainly in my mind.

MR. KARPF: Can I answer your question now?

CHAIRMAN ENTHOVEN: Yes.

MR. KARPF: I think you can get even closer to him. I think, as you've pointed out multiple times, UC has essentially functioned as a prudent buyer and essentially negotiated rates that are substantially better than they had in the past or at least the rate of increase has decreased in a substantial kind of way.

CHAIRMAN ENTHOVEN: They've actually got

decreases, yes?

MR. KARPF: Actually have decreases. And I would point out that some of those savings actually come at the cost of the UC hospitals. And it's been hard to develop an argument to have UC essentially increase the responsibilities to the UC hospitals to make up for some of those savings that they have gained. Yet a rope to get to the argument of the state. Once we get past them, we work on the state next.

MR. WERDEGAR: Dr. Enthoven, I was going to speak earlier. The health centers have quite a few problems, some of their own making. I don't know. I think the question that you raised, Dr. Karpf, so far as this committee is concerned still apply.

I think everybody has agreed that the academic health center should be reimbursed for the complexity of their patient care responsibilities. So some kind of risk adjustment should be taken into account. One of the problems with the academic health centers that came up a good deal in the UC commission on education is the -- is the complete homogenization of patient research and care and budget so that one cannot easily understand which dollar is going for what, and we could probably have a whole separate task force chaired by Dr. Enthoven on education of teaching dollars.

There certainly wouldn't be any reason why those teaching primary care in the community settings shouldn't be rewarded for teaching and only those teaching

in an academic health center be awarded for teaching. So there are a lot of questions about the allocation of the teaching dollars and then where the teaching dollars should come from.

Should they be part of an all-payer system, should they come from part of the Medicare, and so forth. And this is a somewhat separate, although very important issue. Similarly, the research budget seems to make -- is a separate budgetary issue, and it helps greatly in understanding how the academic health centers relate to managed care to separate those three different revenue streams so that we understand what we're talking about.

I felt too that the academic health centers sometimes have a definitional problem. That is that the university hospital only is a county hospital like L.A. County Hospital or San Francisco General Hospital who also have significant relationships to teaching and research.

I'd want to be sure in examining the role of the academic health center that we're not artificially isolating one group of hospitals from others that may have had similar missions. One, it's not a recommendation, but in addition to the issue of proper rewards, because of adverse selection or the complexity of the patients, the issue of access is eventually going to be a question of how major medical centers, the academic health centers, really become parts of integrated health care systems.

That I think is worth the -- deserves the attention of the task force. Because as we look at

managed care plans as integrated health care systems, there is that Quaternary, that highly specialized part that is needed. And so they have to be proper contractual arrangements that do allow access for enrollees to medical centers, and that to integrate the medical centers, which are far to isolated and sometimes rather blind, therefore, to the realities of what managed care and the efficiency that managed care are all about. So some way of properly integrating them into managed care, I think, is something we might want to comment on.

CHAIRMAN ENTHOVEN: In fact, in our conversations about consumer information, one of the ideas of required disclosure or asking disclosure would be if you needed organ transplant and open heart operation, et cetera, where your health plan would send you would be very material information. I think that would be a likely candidate for the kind of thing we would like to ask for a disclosure.

MR. SPURLOCK: I like that piggyback order. And I think when we look at the spectrum of complexity of clinical disease, where you have the center of excellence at one end of the spectrum, and at the other end of the spectrum is the task force that I've heard talked about several times is self care. 75 percent of all medical care is self care. And you have that as a spectrum, where we really definitely need to protect the academic medical centers on this end of the spectrum, where there is specialty care that is unique and can only be obtained at

academic medical.

The difficulty as I see it in the managed care environment is that academic medical centers have been forced to move down that spectrum to less complex medical care. To assume some of the care that some of the community might do in order compete for those dollars, and yet they're competing for those dollars in a way that's very difficult to show return on the investment.

And my challenge is I think we need to both protect and challenge academic medical centers when we move down that spectrum so that the marginal return on investment for the more common less complex disease is clearly greater than the cost benefit that can happen with community providers in that arena.

When you get those high-volume, high common -- not really complex diseases where there is a return investment, a marginal return on investment, but it's challenging to say that is twice as much the cost of what a community provider could save for the average run-of-the-mill congestive heart failure admission or average run-of-the-mill myocardial infarction. It's twice the cost. Then you have to say the marginal investment, the marginal return on investment that we're getting from teaching and research and all the other things are really worth justifying that dramatic of a change, and I think that's the fine line that we're finding ourselves up against, in that we can't allow anybody in the system to not deal with those challenges of marginal return on

investment.

CHAIRMAN ENTHOVEN: Dr. Hopkins, and then I think we'll have to wrap this up.

DR. HOPKINS: Couple of sentences. I think academic centers are moving down the spectrum of complexity not only because they want revenues, but also that they are responding to the need to do more primary education, and you can't do that without really being involved in primary care, even if you do some of the teaching in the community where it should be, and we're willing to pay those people, but there's no money to do that.

I think that the yearning to separate the teaching from the patient care from the research is something that medical centers would like to do, but it's probably impossible. I'll give you a couple of examples.

An oncologist goes to the bedside of a woman who's in the hospital sick with breast cancer. That woman is also involved in two research protocols, and at the bedside with the oncologist is a resident, a senior resident and a junior resident and two medical students.

Is that oncologist doing patient care or is that oncologist doing research or is that oncologist teaching at that moment?

Let's say one of those students is also works for the oncologist in his research organization doing -- helping carry out some part of a research project. Is that student learning to be a researcher, is

that an educational activity, or is that student part of the research enterprise?

That's the way medical centers function. There is an absolutely unmeasurable constant interaction of those functions going on all the time. And I don't think anybody will ever sort that out.

CHAIRMAN ENTHOVEN: It's a genuine joint cost, which according to economic theory is not separable except using arbitrary methods.

MS. CONOM: Just a short comment from the perspective of a doctor.

We're being asked by the HMOs to do a lot of things that haven't been proven. Most of the time when we changed our practices before, it's because of an article that came out from an academic center for research study.

Now we're being asked to change our practice and are, in fact, having to do that by the HMOs. It just seemed to me like there's a natural partnership. The HMOs, for instance, in my field, are studying how in their huge population database they can prevent prematurity, which is a very expensive disease.

It just seemed to me like there's a natural partnership there of academic centers and HMOs, and I do think the HMOs should fund research studies on these issues, especially those which might decrease the cost of medical care.

MR. GURTNER: I just wanted to respond briefly. Unfortunately, because of constraints of time, I

didn't elaborate on my database. But what it says is that the reason that the 20,000 lives are costing one and a half times as much as the 10,000 is solely because there are more sick patients.

The proportion of that group that is sick is 7 percent as opposed to 4 percent. Given the 4 percent group, which is typical of the people around us, the academic physicians don't -- they look after those with exactly the same expense as the community physicians. So there's no difference in cost.

But these two particular patient groups, it's an odd situation because we fell into it by accident. But the reason that the 20,000 lives cost a great deal more is that there are more sick patients, almost double the number of sick patients. But it's a very small group as was mentioned earlier this morning.

The number of really sick patients in the population is on the order of 3 percent in well-selected groups and about 6 or 7 percent in groups that have a higher member.

CHAIRMAN ENTHOVEN: Okay. Thank you very much, doctors, I really appreciate your coming. That was very useful.

(Applause)

CHAIRMAN ENTHOVEN: Now, our expert resource group on the doctor/patient relationship kindly seated their time or suggested under circumstances we carry them over to the next meeting, which brings us to the need to

have some discussion about the complex process about how do we get there from here. Hattie, you want to start by commenting on that?

MS. SKUBIK: Sure.

CHAIRMAN ENTHOVEN: Is it my duty to try to give an explanation?

MS. SKUBIK: I can say something very brief here, and that is that we don't have very many of the task force members with us right now to have this discussion.

The discussion is really supposed to be about the process by which we get to our recommendations and get our report delivered to the government and the legislature by January 1.

So Romero wrote in a letter to each of you suggesting a pretty strict time line for getting there. And that's based on a lot of comments from different task force members about a process they would be comfortable with. What we're thinking a good approach would be is rather than having policy options, work groups, which had been suggested a couple of months ago, many task force members would like to have the policy discussion at the full group level.

Our next three meetings are voting meetings, and so I suspect the task force members will want to be here to vote, and we're hoping to do a process whereby we get your feedback on issues in writing.

So what we would like to try to do is encourage you to fill out those papers, to read the briefs

that we sent you and to get us comments back. Because we're then going to write chapters with recommendations on specific items; for instance, risk adjustment, and then hope to discuss them at the group level for vote on adoption to put together full report for delivery by January 1.

CHAIRMAN ENTHOVEN: Helen?

MS. RODRIGUEZ-TRIAS: I wasn't at the last meeting, so I did lose a perspective of time. It seems to me we have had very little time to process enormous amounts of information. And I for one would like to, you know, declare a moratorium or end to the information feeding in process, and maybe try to go a little bit to what was indicated by Ellen and Jeanne this morning, which is trying to bring us to a consensus about some key points in the -- either through the expert resource group reports or through the larger reports of the -- of the working groups. Because I think we can hang our hats on that hat rack a lot better if we erect the hat rack and come to some agreements on some of the basic areas of accommodation.

MS. SKUBIK: I don't think there's a disagreement there.

CHAIRMAN ENTHOVEN: Ellen, first, I'm much more optimistic than I was at the beginning of this whole process that consensus can emerge on a number of points like improved disclosure of information, risk adjustment, dispute resolution process, et cetera. And we're thinking

we would now be trying to generate papers, send them to everyone on the task force, ask for them to give us their comments and have a "delfoy" questionnaire that would give us a feel for where the members of the task force are, use that feedback to recycle, and then present a semifinal chapter to the task force, and then have a vote for the task force to endorse or accept this paper or not. And if there are recommendations, then, again, put those to a vote.

Does that make any sense to you, Ellen?

MS. RODRIGUEZ-TRIAS: Yes.

CHAIRMAN ENTHOVEN: That's what I think we're trying to do. Peter.

MR. LEE: A couple things. One follow-up. to Ellen's suggestion. The next two meetings have potential time that seems like it is informational. I would suggest we do need time not to hear presentations, but to talk about both the proposals made by the working groups so we can try to reach a consensus around substance. And so there are tentatively scheduled presentations on, you know, the role of medical groups on multicultural issues, research, development, clinical practice, all critically important.

But in four meetings, to hash out issues, I'm very concerned we have a great presentation with the panel today, et cetera, but we have much, much more, I would say very close to exclusive time that is presentation of material prepared by staff or by the

expert resource group so we focus on consensus, which is one suggestion by Ellen which I agree with.

The other that I'm somewhat concerned about is how much we try to use the "delfoy" process to not have discussion here. Is that, like, this morning's discussion, we started with the -- as one example, the consumer information, I think, I can't remember the involvement or information. We had what I thought was consensus in some ways.

This isn't a voting session. I understand the consensus around defining the problem and defining some principals. Staff has that close to written, potentially.

We didn't have consensus on the recommendations because we didn't really get into them. Instead, we had a world of options, and we didn't wrestle with the hard part of what we really wanted to recommend. And I think that one of the challenges in the next four meetings, is -- and this is to the working groups as well as the issue paper groups, whichever, how they come together as a challenge. But we need to be talking more about concrete recommendations that we can get our teeth into.

And so I suggest if it's possible to have the working groups to present at the next meeting to focus more on the substance that we can really try to get into, say, well, what's a concrete recommendation going to be, and things we would absolutely agree on quickly and move

on to those we think are out of bounds anyway.

MS. SKUBIK: Peter, you're in a unique position where you can say exactly what you think publicly and comfortably, whereas many of the task force members are not in that same position and are much more comfortable writing their thoughts out. So we need to do both.

MR. LEE: I appreciate that you think that I can speak publicly, but every single member of the task force is on here to publicly state what their perspectives are, and my concern, my note of reservation is without having the opportunity to discuss issues, if something gets delfoyed at two people on one extreme, if we don't talk about it, maybe the two people can inform everybody else. That's my only concern there.

And I think the delfoy process is fine to get an anonymous poll and to move discussion, but I would certainly hope that every member of this task force -- I know I'm speaking to 7 percent of us now -- is ready to be in groups, share their perspectives. That's how we're going to come to a consensus.

MR. GILBERT: I completely agree with Peter. We're here to talk in public. I think if we have positions, ideas or recommendations, we have to be able to discuss them. What I think you could use the delfoy for potentially would be to figure out what areas we are mainly in consensus, therefore needing a shorter time period versus those that were this far apart, and you

really need to schedule.

I've got to echo Peter and Ellen's comment, though. I think we really got to get into the meat of the discussion. We should probably not do any scheduling of external presentations, and we should focus exclusively on the last ERG, the one or two last ERGs, and then the movement into the papers and the recommendations, because there's a lot of unspoken discussion that has occurred, and I think some of these things are going to take a while to work out. But we have to be able to.

CHAIRMAN ENTHOVEN: We've got to start working on the final packages here.

MR. WERDEGAR: I was going to agree with Peter too. Actually, I was very impressed, Alain, this morning when you gave your sort of brief resume of where we stood. I think all of us have this sense that the process has in its miraculous way, as processes do, brought the group together on a lot of issues.

This morning, you were very briefly summarizing where you thought the task force was, enumerating what some of the key issues were. And I think a little bit more of that now at this stage will give us a sense that we are heading to some pretty positive results. So I would agree with Peter. I do agree too that the discussion has to be public. A certain amount can go on this other way, but we do need public discussion as we reach a consensus.

CHAIRMAN ENTHOVEN: Let me ask your thoughts

on one thing. Diane, I would be interested in your thought about this. How specific do we need to be?

Take something like risk adjustment, on which we've had a lot of discussion now, and my guess is everybody is pretty much persuaded this is an important thing that needs to happen.

I can picture us making a fairly clear statement that explains this is the idea, this is why it ought to happen. If we just put that out there, I can see that having some positive benefits from the point of view of reinforcing and encouraging PERS, perhaps having a positive effect on PBGH, without going to -- proceeding to another level of detail, which is where we say to the legislature not only do we think risk adjustment is important and all that, but we recommend that you pass a law that does such and such. Now, what do you think -- should we be heading for broad policy statements, or do we have to get down something specific?

MS. GRIFFITHS: The more specific you are, the more likely it is the legislature will -- someone will introduce what you have in mind. The more general you are, the more they spin off in an effort to achieve the goal you're trying to achieve, but in a different direction than people in this room had anticipated.

So it's useful to have broad directive. But the more specific they are, the more likely they are to go in the same direction. Now, obviously, the principle is the more specific you are, the harder it may be to get a

consensus in the room.

CHAIRMAN ENTHOVEN: Some of these things depend on some confluence of legislative and voluntary action.

MS. GRIFFITHS: Exactly.

CHAIRMAN ENTHOVEN: So that's valuable advice. So where we can try to --

MS. GRIFFITHS: If what you're seeking to achieve is legislative change.

MS. RODRIGUEZ-TRIAS: There may be some things that may be legislation or some other sectors of shaping things along. So I would say that maybe we should see where that falls out when we have the recommendations.

CHAIRMAN ENTHOVEN: Yeah, I was imagining, for example, one thing with advice to the governor to say we recommend that he direct the Department of Corporations to make a maximum effort to cooperate with public -- with the private sector on CCHRI and other such reporting initiatives, where those activities can meet the public requirements without reinventing the wheel or duplicating. So that would be kind of advice to the governor about policy directives to his own people.

MS. GRIFFITHS: I think the same principal would probably be applicable. The more specific you are, the more likely the governor would be to say yes or no rather if you're more general.

MS. SKUBIK: Because Phil isn't here, I'd like to say on his behalf that something that would be

very useful in this process is to really think about that matrix. He spent a fair amount of time developing that.

Really getting down to specifics just what level of intensity of recommendation do you want to make, task force. Is this something that you want to have as advice or is this something that you want to have as legislation or regulation?

We need to get down to that level, and I encourage you with your ERGs to think about that as you create your matrixes or as we work with you to help create those matrixes of options and then approach with levels of intensity.

MR. LEE: I think we need to move front saying here's the range to -- here's what we need to be talking about. Some cases will end up being very general, and some cases I think we'll make recommendations, I'd expect to private bodies.

For risk adjustment, I would hope we would make a strong recommendation that PBGH do "X." PBGH can say yes or no. That's their option, but it's our recommendation. Similarly, one of the issue raised by the last panel was there's federal issues related to medical education.

I think it's certainly within the domain of this task force to comment on federal issues that impact dramatically our state. You know, we have a small bully pulpit, so to speak, and I think we can't -- to not comment on federal issues because we're the State of

California's Managed Care Task Force, I think it would not be responsible in terms of pretending the federal contact doesn't impact us greatly.

But the more we can wrestle through the specifics, the more the specifics are going to carry weight, which is why the discussions, as we're wrapping up, we need to get more time to not having presentations made to us, so we can talk about either specific recommendations or broad ones.

MS. FINBERG: I would agree with that. And I think what would be helpful is if the staff is going to prepare briefing papers in lieu of the expert research groups of members that they be in terms of possible recommendations that can be discussed yea or nay, as opposed to principals, and maybe one or two recommendations that there's going to be some hot issues where we need to look at that range.

And my guess is, you know, we aren't going to be in agreement at the beginning of the session, maybe we would be closer at the end. I don't know. But I feel very frustrated that we haven't gotten to that level with any of the subjects.

I think that we brushed the issues in a few of the subjects that we've started to discuss, but we haven't determined the level of agreement on any of those issues. And so I really think it would be good to maximize that. I agree with the comments about less presentations, although they are informative. We have to

do our jobs. And I do think it's public. People can write what they think, but at some point, it needs to be stated out loud.

MS. SKUBIK: I would hope that because we already have invitations extended to a small number of people that at least we could allow one hour per meeting for the public to come and give their perspective on managed care. I think that is a process -- this is a public process, and we need to be respectful of all the people who aren't at this table. And I know we've had a lot of sort of health care 101 here, but I think that's what helped to bring the group together, and I feel like they can make some recommendations together. So I hope that you will allow us to at least hear small perspectives from different groups.

MR. GILBERT: Can you explain the difference between -- because you made two different statements. You talked about invitations extended to individuals. You talked about public -- what I consider public testimony and comment, which I see those as two very different things.

MS. FINBERG: Me too.

MR. GILBERT: I think what we're trying to say, the small group of us that are left, is we really don't want formal presentations. We're past that stage. We certainly want comments from the public at all points.

MS. SKUBIK: And you're required to have that.

MR. GILBERT: So I guess what I would say is even if those invitations are extended, I think we're trying to give a clear message here that we've got lots and lots of discussion work to do that's got to be organized.

CHAIRMAN ENTHOVEN: Who are they, Hattie? Is it Dr. Lewin?

MS. SKUBIK: Jack Lewin was going to be here, and then one of our task force members, Terry Hartshorn, had particularly asked for a presentation to be put together from the medical groups of California on just how the funding streams go. And those invitations have gone out for --

CHAIRMAN ENTHOVEN: Are those the only two?

MS. SKUBIK: Those are the only two that I can think of.

MR. LEE: I'm not sure what to do, because it seems very hard to reign in the panel discussions to an hour. If we could say for those two, keep them both for an hour, and we have our block of time to talk. But I'm very concerned that -- and again, we've all talked about the important role of medical groups that will help inform our discussions, but what will help us more is actually talking about the substance of recommendations.

MS. SINGH: I just have a quick recommendation to make, and that is I obviously see the value of having an opportunity for task force members to discuss and debate these issues.

Perhaps those invitations that we've extended for outside presentations, at least schedule those for very last, the very last thing of the day. Therefore, we can have some dedicated time to get down to the important issues of that particular meeting, and then we can have an hour's worth of presentations at the very end. I mean, just for those that have been extended already. We always have to allow for some public comment. We're required, of course, as everyone knows. But perhaps that would reach a happy medium.

MR. LEE: Or another suggestion on the same lines is to note that everyone might be there. We'll have presentation time, which is not voting session that goes from 8:30 to 9:30. And those people who are in L.A. that want to get up early can drive and make it.

MR. FINBERG: Go for the end, Peter.

MR. LEE: Okay. I'll go for the end.

MS. SINGH: And if members wish to hear this presentation, they can stay.

MR. WERDEGAR: I thought we had a CMA presentation?

CHAIRMAN ENTHOVEN: And we also got a nice long letter from him. Look, we had back in 1993 and 1994 some people in Washington who made a disastrous mistake, and that is they absolutely froze out the medical profession out of discussions about --

MR. LEE: I don't think -- the medical profession can't claim that is the case in this process.

MR. SPURLOCK: So we're okay. We've checked that.

MS. SINGH: I think the marginal gape is small.

CHAIRMAN ENTHOVEN: Forever, I think.

MR. SPURLOCK: I talked to Jack, and I think he's going to talk very generally and broadly.

CHAIRMAN ENTHOVEN: I studied their document, which I thought had a lot of interesting ideas. I'm not sure we really need that, and -- but on the other hand, I want to be sure we don't insult leaders of the California medical --

MS. SKUBIK: It's really not -- it's not an issue of a particular interest group. It's an issue of making sure that this is an inclusive process, and allowing one hour for each of our next meetings at the end of the day, I think that's a perfectly nice compromise.

MS. RODRIGUEZ-TRIAS: I just wanted to make one comment. We do have to make a collective agreement that we don't take it out at the end of the day, it's disrespectful.

MR. SPURLOCK: It is.

MR. LEE: It's easy to say to us here.

MS. FINBERG. I think it would be very difficult for some people.

MS. SKUBIK: Somebody made the suggestion of a very early time. Is that better for the task force members? Would you prefer that if we're going to have an

hour --

MR. GILBERT: My only obvious comment is from a scheduling perspective today, we ran out of time for one of the mandated ERGs that is specifically called for in the bill, and we didn't have a chance to do that presentation. We had to put that off to another time because we scheduled things such that it kind of ran into that being the end.

I think we have to have our standard discussion that we are all asking for in the beginning with the presentations at the end, and those of us who are here will be here, and we'll listen to the presentation.

CHAIRMAN ENTHOVEN: That's to start with ERG and the work we've got to do while we're still fresh.

MR. LEE: Could we relay to the ERGs that they try to frame their presentations to focus on the areas we need to talk about, not on the -- we didn't need a consensus here. The ERG presentation we're talking about meaty or fibrous issues.

MR. GILBERT: Since I have Mark Heilpler in our group, we'll --

CHAIRMAN ENTHOVEN: All we have to do is get Terry Hartshorn into your group.

All right. That's been a useful discussion. I think we'll be able to respond to that. Finally, we have three members of the general public who have filed speaker cards. And if they're still here and want to speak, we have Arlis Anderson Rothma, California Coalition

of Nurse Practitioners.

MS. ROTHMA: I'm going to change my hat if I can. I was really here to address the doctor/patient relationship. That didn't get presented. If I could switch my other hat, which is from the University of California Commission on the Future of Medical Education, which Charlie Wilson and I staff, and I think we sent you our reports, and that speaks a little bit to Rebecca's concern that academic medicine is stonewalling.

One of the major things we called for in that report was an integration saying to UC you must integrate and collaborate with managed care organizations to train students, medical students, and other health care professional students as well.

So we really put heavy weight on that as an important movement for academic medicine and health care training, but I think we also have to look at the other side. We know, those of us who are in the finance of GME, we know than the IME portion has been going to them for a long time, with that of the ACC cap, and that's been going to them for a long time without them really reciprocating educational experience.

We need to call managed care organizations to the plate and ask for their help. And I would love some ideas of economic incentives or managed care organizations to participate in the educational process. I think it's very, very important.

My other piece that I was going to talk

about for the California Coalition of Nurse Practitioners, we sent you a letter. And I'll talk to Sara more about that. It's, in fact, based on the funding streams and the way the medical groups are getting money.

We are having a lot of trouble in terms of getting reimbursement for practitioner practice as well as midwife practice in the state, and I need to talk to you about that. But I can do that in a different format. If you're not going to have the doctor/patient discussions or the fund stream discussions, we can make public comment at the next session anyway. Is that the way that will work?

MR. LEE: We will be having those discussions.

MS. ROTHMA: You just won't have the presentations?

CHAIRMAN ENTHOVEN: We'll have the presentations and discussions.

MS. FINBERG: We're having them by task force members. It's the outside presentations we're trying to cut back. And here we have members we're going to present.

CHAIRMAN ENTHOVEN: Thank you very much.

Lynnie Morgan. Parent, founder, director. She's here. Welcome back.

MS. MORGAN: Hello.

CHAIRMAN ENTHOVEN: Is this your fourth consecutive appearance?

MS. MORGAN: Appearance, yes. I don't have

to sing or anything, do I? Do I need to wake you up? Maybe I can do a little rendition of Amazing Grace.

Actually, what I would like to address, I really was looking forward to talking -- addressing the doctor/patient relationship because I think if we weren't here, if we didn't have that issue, that the patient wasn't getting what they needed from their HMO or caregiver, we wouldn't even have the need for the task force.

So the bottom line is that the patient isn't getting what they need at this time. And I think that it's interesting today that you talked about risk adjustment. And I think that what I heard today from Dr. Left was extremely encouraging from a consumer viewpoint.

However, I think that there's something that was missed today in the presentation, and that was that the adjusting is going to be highlighting politically correct diseases, if you will. So AIDS, a lot of people have AIDS, and there is an easy way to diagnose AIDS.

And I think that diabetes is a popular disease. People who are easily diagnosed with diabetes are going to be addressed. Their needs will be addressed. But there's a segment of the population that's not going to be addressed by needs adjustment.

When you make your recommendations, when you have your discussions, it's really wonderful to talk about serving those populations, those large amounts of populations. And if you want to pursue your

recommendations for that, to me what you're saying to the consumer is that might is right, because it's a large population and they are easily diagnosed, that they get the funding, and are in that -- in that perspective --

CHAIRMAN ENTHOVEN: I think part of it is when you're trying to explain it to people who aren't familiar with it, it's easier to talk in terms of diseases that are fairly familiar.

But I think in the actual statistical and actual mathematical model, they're reaching out for everything they can get their hands on including infrequent and costly diseases.

Maybe in some cases when you say organ disease, they just have a very hard time coming up with the diagnostic measurements that are defined and so forth.

But I'm sure that part of the idea of the research methodology is to try to deal with that problem. So this is not -- this is not an exercise that's saying let's respond to the people with AIDS and diabetes because they're organized and well known. It's an exercise in trying to deal with all of the diagnoses and convert those into their economic significance.

MS. MORGAN: What I heard today in the terminology was that the diagnosis would be an integral part of the process of giving monies or balancing out monies, and what I'm saying to you is that there is a large segment of the population that has no diagnosis.

Which, for example, when our daughter was

denied services through our HMO. I went and filed the with the California Department of Corporations after of going through the grievance process, but I also went to the press and picketed my HMO for six months.

Kaiser, which is my HMO, told the press that my daughter had no diagnosis. Now, scrawled all over her charts is suspected mitochondrial encephalitis. According to my HMO, my daughter has no diagnosis, and I guess what I'm saying is that I am concerned that the task force is going to take recommendations, and that the wording is going to be that those people are like my daughter and other people who have mitochondrial disease or other organ diseases, are, once again, because in the HMO, they are very much relegated to the bottom of the rung, and ask me about it.

I asked for services for my child, and I speak to hundreds of people a year, 1,000 people within the last two years, who are having extreme amounts of problem getting services and diagnosis from their HMO because they're -- the terminology -- and it's too bad Steve's not here for the interpretation of the wording, allows the health maintenance organization to deny those services.

And I think -- I'm sorry I'm not going to be able to go to Southern California to hear the patient/doctor relationship. I can't afford to fly down there. But if I were there, I would say that is the crux of the doctor/patient relationship, and the -- and the

degradation of that relationship by perverse incentives is going to be now further destroyed by not taking those out, and by adding on more wording that really delegates those with chronic serious illness to again the bottom of the barrel.

I'm just asking you as a task force to be sensitive to the wording. That's all I'm -- that's what I'm presenting to you. Because -- be careful of the wording. And I just recommend that you are extremely careful not to exclude those of us who need medical care that don't fit into any slots. Try to think outside of the box.

MR. SPURLOCK: I think this really speaks to the issue of how do you risk adjust Gaucher's disease. When they're rare and very expensive diseases and not common, it's hard to risk adjust using our typical models, even if we have great models. And that's sort of why I was alluding to earlier to the notion of carving out. There may be certain situations that you want to carve out these rare diseases that you couldn't risk adjust in any situation because of the statistical validity or whatever. And we have a separate class that we carve out, and we insure that class as a CCS of adults, that kind of thing.

CHAIRMAN ENTHOVEN: Sure. I think that makes a lot of sense. And I think carving out Gaucher's disease is a good illustration because it's so infrequent and so costly.

And one could imagine as part of this whole

system having certain designated regional centers, just say those patients will be sent there, and payment will be broadly based. And every health plan will contribute for something.

MR. SPURLOCK: Like CCS?

CHAIRMAN ENTHOVEN: And, in fact, this is going to have to be trial and error and experimentation, and different approaches. There is still a lot of art in this.

The last thing that I'd like to mention too is that the National Organization for Rare Disorders has a newsletter called the Organ Disease Update. In the -- in two issues ago, they actually talked about the implications of academic organizations not getting referrals, HMOs.

When patients, such as my daughter or people with AIDS are not referred to medical centers, for example, here in California or even, say, sent to Emery University for testing, then those -- they not only miss out on the financial level, but we sort of cut our nose off to spite our face, because those doctors don't get experience with those rare disorders. So

I would also ask that the task force consider that you sort of shoot yourself in the foot when you -- when you limit or when you don't regulate and you limit a referral system. You have a self-limiting referral system for parents. The patient loses out. The state loses out. But the whole United States loses out on

a federal level, and the world at large loses out.

What would have happened if people hadn't seen the AIDS patients that lived outside of our country and outside of our state? So I thank you very much.

Mr. Bishop, we have all lost a great advocate. I'm very sorry. I'm happy for you, but I'm sorry for the consumers and the patients who are losing you because you are a treasure.

CHAIRMAN ENTHOVEN: Mr. Butley, California Association of Catholic Hospitals.

MR. BUTLEY: I promise to be very brief. With all deference to the chairman, we had the admonition earlier today of staying focused on issues on this committee. I want to take advantage of the invitation that this commission put out last May where they had a series of questions I brought with me, in terms of is there a right to health care. We're going to issue a policy paper on that and submit it to you in time for your November meeting.

I'm a realist. I know that's not going to get woven into the fabric of this document. But I think it's important to keep that kind of a question on the table out there for future debate, because, quite frankly, one out of five Californians not being insured and the connection between insurance and health status, California as an organism, we are 20 percent sick. We've got a big problem that this commission can't handle. You're doing good work, but we can't look at it in isolation like that.

So we're going to have to come to grips with how we look at health care. Is it a social good? Is it a market commodity? And then we have to figure out which way we want to go. That's a collective decision.

I'm wanting to see if I could get that to the commission so they can get background ahead of the commissioners. We will be discussing it further down the road, but I wanted to give you a heads up that that was coming so it wasn't a surprise.

CHAIRMAN ENTHOVEN: Thank you. All right. We will consider the meeting adjourned.

(Whereupon the proceedings were adjourned at 5:00 p.m.)

STATE OF CALIFORNIA)
) ss.
COUNTY OF SACRAMENTO)

I, SERENA WONG, RPR, CSR NO. 10250, a Certified Shorthand Reporter in and for the State of California, do hereby certify;

That said proceeding was taken down by me in shorthand at the time and place named therein and was thereafter reduced to typewriting under my supervision;

That this transcript is a true record of the testimony given by the witnesses and contains a full, true, and correct report of the proceedings which took place at the time and place set forth in the caption hereto as shown by my original stenographic notes.

I further certify that I have no interest in the event of the action.

EXECUTED this 29th day of September 1997.

SERENA WONG, RPR, CSR NO. 10250